

EFFECTIVENESS OF A CHILD-CENTERED SELF-REFLECTIVE
PLAY THERAPY SUPERVISION MODEL

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This study investigated the effectiveness of a child-centered self-reflective play therapy supervision model with master's level counselor education graduate students. Specifically, this research determined if the self-reflective play therapy supervision model facilitated significant change in the master's level play therapists': (a) child-centered attitude; (b) knowledge of child-centered play therapy; and (c) confidence in applying play therapy skills. This study also measured change in the skills of: (d) tracking behavior, (e) reflecting content, (f) reflecting feelings, (g) facilitating decision-making and self-responsibility, (h) facilitating esteem-building and encouragement, (i) encouraging the child to lead, (j) setting limits, (k) ability to be congruent, (l) quality of non-verbal responses and (m) quality of verbal responses.

The experimental group students (N=15) utilized a 15 week self-reflective play therapy supervision model. This model consisted of a manual that reviewed the rationale and utilization of six therapeutic responses of child-centered

play therapy, self-assessment forms that were completed after reviewing weekly play therapy session videos and weekly group supervision. The control group (N=15) received supervision during the 15 weeks but did not use the manual or the self-assessment forms. Prior to working with their first client and again at the end of the semester practicum, the play therapy supervisees completed the Play Therapy Attitude-Knowledge-Skills Survey. Each supervisee submitted a pre-tape and a post-tape of a play therapy session during their semester practicum. Four doctoral students rated play therapy session video tapes using the Play Therapy Skills Assessment form. The play therapy session video tapes were assessed by objective raters.

An independent t-test utilizing the gain score as the dependent variable revealed that play therapy supervisees in the experimental group showed a statistically significant increase in their ability to implement the skill of tracking behavior, facilitating decision-making and self-responsibility and facilitating esteem-building and encouragement. In addition, the experimental group supervisees showed a significant increase in the quality of their verbal responses and a marginally significant increase in their ability to reflect content and reflect feelings. Limited statistical significance in the play

therapy supervisee's improvement of skills possibly could be attributed to the small sample size and lack of random assignment of participants to the experimental and control group.

The positive trends in the play therapy supervisees increased ability to implement play therapy skills warrants additional research of the self-reflective supervision model.

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TABLE OF CONTENTS

Chapter	Page
1. INTRODUCTION	1
Purpose of the Study	5
Synthesis of Related Literature	6
Counselor Supervision	6
Counselor Supervision Models	7
Play Therapy Training	17
Play Therapy Supervision Models	27
2. METHODS AND PROCEDURES	31
Definition of Terms	31
Hypotheses	39
Instrumentation	41
Play Therapy Attitude-Knowledge-Skills Survey .	41
Play Therapy Skills Assessment	42
Selection of Participants	47
Collection of Data	48
Procedures: 15 Week Child-Centered Self-Reflective Play Therapy Supervision Model	49
Data Analysis	57
3. RESULTS AND DISCUSSION	60
Results	60
Discussion	90
Play Therapy Attitude-Knowledge-Skills Survey .	90
Play Therapy Skills Assessment	93
Limitations	99
Implication	101
Recommendations	103
Conclusion	104
APPENDICES.....	105

A. Informed Consent Forms	106
B. Play Therapy Attitude-Knowledge-Skills Survey	110
C. Play Therapy Skills: Rater-Assessment	116
REFERENCES.....	117

LIST OF TABLES

Table	Page
1. Mean scores on the Play Therapy Skills subscale of the Play Therapy Attitude-Knowledge-Skills Survey (PTAKSS)	63
2. Analysis of covariance data for the mean scores on Play Therapy Skills subscale of the Play Therapy Knowledge-Attitude-Skills Survey (PTAKSS)	63
3. Mean scores on the Play Therapy Attitude subscale of the Play Therapy Attitude-Knowledge-Skills Survey (PTAKSS)	64
4. Analysis of covariance data for the mean scores on Play Therapy Attitude subscale of the Play Therapy Knowledge-Attitude-Skills Survey (PTAKSS)	65
5. Mean scores on the Play Therapy Knowledge subscale of the Play Therapy Attitude-Knowledge-Skills Survey (PTAKSS)	66
6. Analysis of covariance data for the mean scores on Play Therapy Knowledge subscale of the Play Therapy Knowledge-Attitude-Skills Survey (PTAKSS)	66
7. Mean scores on Tracking Behavior on the Play Therapy Skills Assessment (PTSA)	69
8. Average gain scores on Tracking Behavior on the Play Therapy Skills Assessment (PTSA)	69
9. Analysis of t-test for equality of mean scores on Tracking Behavior on the Play Therapy Skills Assessment (PTSA)	70
10. Mean scores on Reflecting Content on the Play Therapy Skills Assessment (PTSA)	71

11. Analysis of covariance data for the mean scores on Reflecting Content on the Play Therapy Skills Assessment (PTSA)	72
12. Mean scores on Reflecting Feelings on the Play Therapy Skills Assessment (PTSA)	73
13. Analysis of covariance data for the mean scores on Reflecting Feelings on the Play Therapy Skills Assessment (PTSA)	73
14. Mean scores on Facilitating Decision-Making and Self-Responsibility on the Play Therapy Skills Assessment (PTSA)	74
15. Average gain scores on Facilitating Decision-Making and Self-Responsibility on the Play Therapy Skills Assessment (PTSA)	75
16. Analysis of t-test for equality of the mean scores on Facilitating Decision-Making and Self-Responsibility on the Play Therapy Skills Assessment (PTSA)	76
17. Mean scores on Facilitating Esteem-Building and Encouragement on the Play Therapy Skills Assessment (PTSA)	78
18. Average gain scores on Facilitating Esteem-Building and Encouragement on the Play Therapy Skills Assessment (PTSA)	78
19. Analysis of t-test for equality of the mean scores on Facilitating Esteem-Building and Encouragement on the Play Therapy Skills Assessment (PTSA)	79
20. Mean scores on Directed the Child on the Play Therapy Skills Assessment (PTSA)	81
21. Analysis of covariance data for the mean scores on Directed the Child on the Play Therapy Skills Assessment (PTSA)	81
22. Mean scores on Setting Limits on the Play Therapy Skills Assessment (PTSA)	82

23. Analysis of covariance data for the mean scores on Setting Limits on the Play Therapy Skills Assessment (PTSA)	83
24. Mean scores on Voice Incongruent on the Play Therapy Skills Assessment (PTSA)	84
25. Analysis of covariance data for the mean scores on Voice Incongruent on the Play Therapy Skills Assessment (PTSA)	84
26. Mean scores on Non-Verbal Responses on the Play Therapy Skills Assessment (PTSA)	85
27. Analysis of covariance data for the mean scores on Non- Verbal Responses on the Play Therapy Skills Assessment (PTSA)	86
28. Mean scores on Quality of Verbal Responses on the Play Therapy Skills Assessment (PTSA)	87
29. Average gain scores on Quality of Verbal Responses on the Play Therapy Skills Assessment (PTSA)	88
30. Analysis of t-test for equality of the mean scores on Quality of Verbal Responses on the Play Therapy Skills Assessment (PTSA)	89

CHAPTER I

INTRODUCTION

Play therapy is a specialized field requiring training and supervision that focuses not only on the development of play therapy skills but also on understanding the child's perceptions and experience. The clinical supervision process facilitates the play therapist's development of personal insight and assists the play therapist in gaining knowledge about self, the child, and the therapeutic process (Guerney, 1983; Landreth, 1991).

Play therapy is a special area of training requiring attitudes and skills not typically found in most adolescent or adult training programs in the helping profession field. Seldom, if ever, are therapists with adults confronted with a reluctant client who cries, falls on the floor and refuses to go into the therapist's office, or a client who says nothing for the entire session, or a client who is significantly developmentally below the therapist's level of abstract reasoning ability, or a client who tries to

throw things at the therapist, or a client who repeatedly acts out the same fantasy scenes (Landreth, 1991, p. 105).

Therefore, it is imperative that play therapists receive specialized supervision. The International Association for Play Therapy requires an individual applying to become a registered play therapist to acquire two years of supervised experience that includes 2,000 hours of direct clinical work. A minimum of 500 hours must be direct contact hours of play therapy with a minimum of 50 hours of supervision (APT Newsletter, 1992).

Although quality play therapy training and supervision is clearly needed, the Directory of Play Therapy Training published by the Center for Play Therapy at the University of North Texas listed only 83 universities that offered at least one three-credit graduate course in play therapy in the United States and Canada (Center for Play Therapy, 2000).

Numerous counselor educators have theorized about the purpose of counselor supervision. According to Holloway (1995), a counseling supervisory process should incorporate monitoring-evaluating, instructing-advising, modeling, consulting, and supportive-sharing. These experiences

assist supervisees in developing counseling skills, emotional awareness and the ability to self-evaluate, conceptualize cases, and develop into professional and competent therapists.

Loganbill, Hardy and Delworth (1982) asserted that effective supervision helps counselors develop competence, emotional awareness, autonomy, identity, respect for individual differences, purpose and direction, motivation, and professional ethics.

Mueller and Kell (1972) described several essential dimensions of the supervisory relationship including trust between the supervisor and the supervisee, a sense of security, warmth, openness, and the ability to openly explore feelings and conflicts. In addition, they stated that effective supervisors provide emotional support as supervisees experiment with new insights, feelings, and relationships.

According to Tracy, Ellickson, and Sherry (1989), counseling supervision styles that offer little structure may increase the supervisee's level of anxiety. They also reported that beginning supervisee's perceive themselves as needing more structure than more advanced supervisees.

Although information about the principles, theory, and skills of play therapy has been published since the early 1900's, few supervision models discuss the application of this information. A literature search on play therapy supervision revealed only two publications that discussed specific play therapy supervision models (Bradley & Friedrich, 1982; Bratton, Landreth & Homeyer, 1993).

Play therapists need to internalize a philosophy of how to effectively interact with children. The child-centered play therapist believes that through trusting the inner strength of the child, the child will respond with inner direction, creativity and self-healing power (Landreth & Sweeney, 1997). Therefore, child-centered play therapy supervision should focus on these areas during the supervisory process.

A theoretical structured model of play therapy supervision is needed to enhance the professional development of child-centered play therapy supervisees. Beginning child-centered play therapists need to understand the principles and theory of child-centered play therapy, to have a child-centered attitude and to utilize genuine and effective therapeutic responses (Landreth, 1991).

Although play therapy supervision is essential to the development of effective play therapists, little information is available about play therapy supervision (Kranz & Lund,1994). The effects of a play therapy supervision model on play therapy supervisees has not been researched. More specifically, the effects of a supervision model that aids in the development of child-centered play therapy supervisees has not been investigated.

Purpose of the Study

This study examined the effectiveness of the Child-Centered Self-Reflective Play Therapy Supervision Model on the growth and development of child-centered play therapy supervisees. The Child-Centered Self-Reflective Play Therapy Supervision Model was designed by the author to supervise master's level play therapists who were enrolled in a university counseling practicum course (Giordano, Landreth & Bratton,1999). This study was designed to determine the effects of The Self-Reflective Play Therapy Supervision Model on child-centered play therapists' knowledge of play therapy, application of therapeutic skills, and attitude toward children. In addition, the effects of The Self-Reflective Play Therapy Supervision

Model on child-centered play therapists' development of specific skills were analyzed. These skills include

- (a) tracking behavior; (b) reflecting content;
- (b) reflecting feeling; (d) facilitating decision-making and self-responsibility; (e) facilitating esteem-building and encouragement; (f) encouraging the child to lead;
- g) setting limits; (h) ability to be congruent; (i) quality of non-verbal responses; and (j) quality of responses.

Synthesis of Related Literature

This review is a synthesis of literature related to:

- (a) counselor supervision; (b) counselor supervision models; (c) child-centered play therapy training; and
- (d) play therapy supervision models.

Counselor Supervision

Counselor supervision is an essential part of a counselor's development. The three main purposes of supervision include the facilitation of personal and professional development, counselor competence, and accountable counseling and guidance programs. Usually, the supervision process encourages the counselor to self-initiate personal growth and development. Professional development encompasses several tasks including integrating the image of the profession into the counselor's self-

concept and making a commitment to the professional role and function as a counselor. Additional tasks of a counselor's professional development include committing to institutional goals in which counseling services are performed and recognizing the significance of the profession for individuals and our society (Bradley, 1989).

Counselor supervision also facilitates the development of a counselor's competency through helping the counselor obtain and refine counseling skills. Supervision teaches counselors to be accountable by explaining their function to the community and by evaluating the effectiveness of their services (Bradley, 1989).

Counselor Supervision Models

Counselor supervision models provide clinical supervisors diverse theoretical frameworks for understanding and facilitating an effective supervision process. The following models were reviewed and elements of each were integrated into a Child-Centered Self-Reflective Play Therapy Supervision Model developed for this project.

Developmental Model

Loganbill, Hardy, and Delworth's (1982) developmental supervision model includes three stages: stagnation, confusion, and integration. They proposed that during the

initial stage, stagnation, the supervisee has a naïve unawareness of important supervisory issues and is insecure about his or her counseling abilities. The supervisee is viewed as a dichotomous thinker who is extremely dependent on the supervisor.

Loganbill, Hardy, and Delworth (1982) suggested that in the second stage, confusion, the supervisee feels disorganized, confused, and becomes aware of personal limitations. The supervisee vacillates between feeling like an expert and feeling incompetent. It is common for the supervisee to feel disappointed or angry towards the supervisor for not providing answers.

The third stage, integration, is a reorganization and integration stage in which the supervisee devises creative solutions and is aware of personal strengths and limitations. The supervisee develops a more realistic view of the supervisor and is able to remain flexible and open to continued growth.

Eight developmental issues are addressed in this supervision model: competency, emotional awareness, autonomy, identity, respect for individual differences, purpose and direction, personal motivation, and professional ethics (Loganbill, Hardy, & Delworth, 1982).

The Self-Reflective Play Therapy Supervision Model developed for this study was designed to encourage competence by having the supervisees learn therapeutic responses through reading the play therapy manual, completing worksheets, and reviewing and assessing weekly play therapy session videotapes.

During the stagnation stage in which the supervisee may perceive the supervisor as omnipotent or irrelevant, the Play Therapy Self-Reflective Supervision Model empowered the supervisee to review weekly play therapy sessions on videotape and engage in a self-assessment process. This encouraged play therapy supervisees to become more autonomous and to identify specific areas they wanted to address during weekly supervision meetings.

The Discrimination Model of Supervision

In the discrimination model of supervision, Bernard (1979) described the supervisor's role as that of teacher, counselor, and consultant. The supervisory role of teacher helps the supervisee learn skills and therapeutic responses that facilitate the client's growth and development. In addition, the supervisor assists the supervisee in learning how to conceptualize the client and to understand patterns and themes of the client's thought. Lastly, the supervisor

focuses on personalization that is described as the process of increasing the supervisee's awareness of how his or her attitudes, feelings, and behavior influence the client and the counseling relationship.

In supervising beginning play therapists, the supervisor is most likely to utilize the roles of teacher and counselor. The Self-Reflective Play Therapy Supervision Model primarily focuses on the supervisor's role as teacher. The supervision model provides information about the types of therapeutic responses and the rationale for utilizing specific responses. The model also addresses issues such as congruence, quality of verbal and non-verbal responses, and ability to connect with the child.

Psychotherapeutic Model of Supervision

The Psychotherapeutic Model of counselor supervision utilizes the principles of counseling and psychotherapy in the supervision process (Heppner & Handley, 1981; Rogers 1957). This supervision model concentrates on both interpersonal and intrapersonal dynamics in the counseling relationship. Interpersonal dynamics encompass both verbal and nonverbal feedback that is exchanged between the counselor and client, the counselor and the supervisor, and the supervisor's role in insuring quality contact between

the client and counselor. Intrapersonal dynamics refers to the feelings, thoughts, perceptions, and beliefs of an individual. The supervision process addresses the intrapersonal issues of the client, the counselor, and the supervisor. The two main goals of dynamically oriented supervisors are for the counselor to learn and understand what is therapeutic, and for the counselor to have a therapeutic effect on the client (Mueller & Kell, 1972).

According to Bradley (1989), one of main approaches utilized in providing psychotherapeutic supervision is interpersonal process recall (IPR). Developed by Kagan and Krathwohl (1967), IPR is a process in which the supervisor and counselor review an audio or videotape of the counselor and client. The main purpose is to assist the counselor in understanding the dynamics of the session and to identify thoughts and feelings that interfered with the communication process. This process also helps the counselor identify underlying messages in the client's verbal and nonverbal behavior. The tape is stopped during an interaction and the counselor is asked questions about how the client was feeling, what the client was communicating, how the client perceived the counselor, and how the counselor wants to be perceived. In addition, the

counselor is helped to examine the counselor's own feelings and the quality of therapeutic responses. Supervisors ask questions when a shift, such as changes in tone, body posture, affect, misunderstanding, or inappropriate affect, has occurred in the therapeutic process (Kagan and Krathwohl, 1967).

The Self-Reflective Play Therapy Supervision Model utilized Interpersonal Process Recall (IPR) during supervision meetings to assist the supervisee in developing greater awareness about how intrapersonal processes influenced the dynamics between the play therapist and the child. IPR was utilized to increase the play therapist's ability to be genuine, warm, congruent, empathic, and to provide unconditional positive regard.

Behavioral Model of Supervision

Although the main emphasis of behavioral supervision is on the skill behaviors of the supervisee, these skill behaviors are defined to include the supervisee's thinking, feeling, and acting behaviors. Behavioral supervision is a five-step process that includes: establishing a relationship between the supervisor and counselor, skill analysis and assessment, setting goals for supervision,

identifying and implementing strategies, and evaluating and generalizing learning (Bradley, 1989).

A relationship based on mutual respect and understanding between the supervisor and counselor is first developed (Bradley, 1989). According to Delaney (1972), the relationship is so critical to the supervisory process that a working alliance needs to be established prior to providing the counselor feedback regarding skills and abilities.

Once a working alliance is established, the supervisor addresses skill analysis and assessment. The supervisor and counselor define in behavioral terms specific skills necessary for effective counseling. Then, each of the counselor's skills is assessed. The supervisor creates a model of ideal skills the counselor can strive to obtain. Supervision goals are then established by the counselor which are based upon specific skill behaviors defined during the analysis (Bradley, 1989).

Delaney's (1972) emphasis on developing a positive working relationship prior to providing the supervisee feedback was incorporated into the Self-Reflective Play Therapy Supervision Model by encouraging the supervisor to create a safe atmosphere and develop a positive working

alliance. During the first supervisory meeting, the supervisor and supervisee discussed their clinical experience, personal background, and expectations of the supervisory process.

Another aspect of the behavioral supervision model that was incorporated into the Self-Reflective Play Therapy Supervision Model, was the identification of a specific set of therapeutic skills to be implemented by the child-centered play therapy supervisee. This set of therapeutic skills provided the basis for skill analysis and assessment. The Play Therapy Assessment of Therapeutic Responses, the Therapist's Corrected Responses and the Play Therapy Counseling Skills Assessment were utilized on a weekly basis to help the supervisee and supervisor assess skill development. These assessments provided the basis for the supervisor and supervisee to collaboratively decide on future goals for learning and skill development.

Micro-training

The initial micro-training model developed by Ivey et al. (1968) focused on helping beginning counselors acquire the skills of attending, reflecting and summarizing feelings. According to Ivey (1972), microtraining is a

systematic approach to learning specific counseling skills utilizing the following steps.

1. The trainee attempts to perform the focal skill within a situation where it is appropriate. This attempt at performance could be a simulated, coach-client, role-played exercise.
2. The attempted performance is videotaped.
3. If the performance was of an interpersonal skill, the other party completes an evaluation form, and may be interviewed for additional feedback. When the focal skill does not involve another party this step can be eliminated.
4. The trainee reads a manual describing the focal skill to be learned. The supervisor is available for discussion and clarification of the focal skill.
5. Video models of an expert demonstrating the skill are shown to the trainee, and these may be positive or negative models. Discrimination training is present as the supervisor and trainee discuss the models.
6. The trainee and supervisor critique the videotaped attempt (step 1) to perform the focal skill.

Discrimination is again present as the trainee identifies examples where the focal skill was performed satisfactorily, poorly, or not at all. The supervisor offers verbal reinforcement for capable skill performance.

7. The supervisor and trainee plan and prepare for another performance of the focal skill.
8. The trainee makes a second attempt to perform the focal skill, and this is videotaped.
9. Feedback and evaluation are made available to the trainee (pp.8-9).

According to Ivey (1971), one of the strengths of the microtraining program is that the trainee is encouraged to develop one skill at a time. In addition, the trainee is provided an opportunity to observe and confront specific ineffective behaviors. Trainees learn from videotapes and by practicing each skill in role-plays.

The Self-Reflective Play Therapy Supervision Model utilized Ivey's microtraining during the second and third supervisory meetings. During the second meeting, the child-centered play therapy supervisees reviewed the skills of tracking behavior, reflecting content, reflecting feelings,

and facilitating decision-making and self-responsibility. At the third play therapy supervisory session, the child-centered play therapy supervisees reviewed how to facilitate esteem-building and encouragement, set limits, and facilitate creativity and spontaneity. Each therapeutic skill was discussed one at a time. After the first skill was discussed, the supervisor modeled the skill. Then, each play therapy supervisee was given an opportunity to implement the skill. The supervisor, who was playing the part of the child, provided feedback.

Play Therapy Training

This study focused on three major components child-centered play therapy supervisees need to develop to become effective play therapists. These areas include the development of a child-centered attitude, knowledge of play therapy, and play therapy skills. The next section presents the principles, attitudes and beliefs of a child-centered play therapist and research focused on play therapy training.

Theoretical Foundation of Child-Centered Play Therapy

In addition to knowledge and clinical skills, a child-centered play therapist needs several personal qualities to develop an effective and therapeutic relationship with a

child. Rogers (1962) described three personal qualities as essential to the therapeutic process with all clients.

First, the play therapist needs to be congruent which Rogers (1962) defined as the ability to be "genuine and without 'front' or facade, openly being the feelings and attitudes which at that moment are flowing in him" (Rogers, 1962, p. 417.) Second, it is essential that the play therapist have accurate empathic understanding for the child. Rogers defined this as sensing "the client's inner world of private personal meanings as if it were your own, but without ever losing the 'as if' quality..." (Rogers, 1962, p. 419). Third, instead of judging or criticizing the child, the play therapist feels positive regard for the child. The child is more likely to experience growth when the play therapist "is experiencing a warm, positive, acceptant attitude toward what is in the client" (Rogers, 1962, p. 420).

Axline (1947) applied the basic tenants of Roger's theory to play therapy and developed eight principles for working with children. The child-centered play therapy supervisee needs to understand these principles as well as the logic and rationale for implementing these principles. Axline believed in making no effort to control or change

the child. She described the overall objectives of play therapy as helping the child develop self-awareness, self-direction, and the ability to identify and accept personal feelings. The eight principles are:

1. The therapist must develop a warm, friendly relationship with the child, in which good rapport is established as soon as possible.
2. The therapist accepts the child exactly as he is.
3. The therapist establishes a feeling of permissiveness in the relationship so that the child feels free to express his feelings completely.
4. The therapist is alert to recognize the feelings the child is expressing and reflects those feelings back to him in such a manner that he gains insight into his behavior.
5. The therapist maintains a deep respect for the child's ability to solve his own problems if given an opportunity to do so. The responsibility to make choices and to institute change is the child's.
6. The therapist does not attempt to direct the child's actions or conversation in any manner. The child leads the way; the therapist follows.

7. The therapist does not attempt to hurry the therapy along. It is a gradual process and is recognized as such by the therapist.
8. The therapist establishes only those limitations that are necessary to anchor the therapy to the world of reality and to make the child aware of his responsibility in the relationship (Axline, 1947, pp. 73-74).

Axline's principles describe how play therapists create therapeutic relationships with children. Child-centered play therapists believe that the therapeutic relationship is essential for a child's emotional growth and development (Axline, 1947; Moustakas, 1959; Landreth, 1991). In fact, according to Axline (1947), the relationship determines whether or not therapy is successful. A therapeutic relationship is created through a sincere attitude and an ever-present appreciation for what the child is saying and doing. An attitude of kindness, understanding, respect, and acceptance must be present in the child-centered play therapist (Axline, 1947; Landreth, 1991). In addition, empathic responses help the child-centered play therapist communicate understanding of the child's world. As children begin to feel deeply understood,

they feel safe to become more engaged in the relationship and their perception of the world begins to change (Landreth, 1991).

Play Therapy Training Research

According to Kranz (1978), beginning play therapists often have a misconception that the play therapy process is fun and that the necessary therapeutic skills needed have been developed through general life experiences. Kranz suggested that beginning play therapists often view children as helpless, feel an intense desire for the child to like them, and are anxious about permanently damaging the child. Kranz proposed that, in time, beginning play therapists learn that limits and guidelines enhance the child's growth and that therapeutic growth can occur without verbalization from the child.

Linden and Stollak (1969) designed a play therapy training effectiveness study comparing two training procedures. Undergraduate students in the first experimental group received six weekly, ninety-minute play therapy training sessions. Participants were taught the basic principles of non-directive play therapy in a didactic manner. They were instructed to reflect the child's verbal and nonverbal feeling and content and were

told not to give direction, help, or information unless it was requested. Students were also taught not to ask the child questions and if they decided to praise a child, they were asked to praise the behavior, not the person. Lastly, they were told to pay close attention to the child and to state limits if the child began destroying an item in the playroom.

Students in the second experimental group participated in six, weekly ninety-minute discussions about the ideal way to interact with children. Initially, the leader presented scenarios for discussion, e. g., "While playing with Mary, who seems very angry about something, she starts hitting and kicking you. What would you do and why" (p. 215)? The leader used similar questions to facilitate the discussion and responded to the group member's questions and statements by reflecting and summarizing. Members of the control group did not participate in a training group. All 48 participants conducted two, 20-minute pre-training and post-training play therapy sessions which were coded by nine coders.

Results of the study indicated that beginning play therapists who received didactic training were more capable of reflecting non-verbal expression of feelings and

utilized fewer directive statements and behaviors than the beginning play therapists whose questions and statements were reflected and summarized. Linden and Stollak concluded that directive and didactic play therapy supervision models may be most effective in helping beginning child-centered play therapists learn to respond and behave in a therapeutic manner.

Arnold (1976) studied the use of micro-counseling procedures to teach play therapy practicum students the three specific skills of reflecting feelings, reflecting content, and setting limits. The results of his study indicated that micro-counseling significantly impacted the student's ability to reflect feelings and content and to set limits.

Kao and Landreth (1997) assessed the efficacy of a 15-week, 45-hour introduction to play therapy course. The experimental group consisted of 37 female, graduate student volunteers who were enrolled in three sections of an Introduction to Play Therapy course. The control group consisted of 25 female and 4 male volunteers who were enrolled in graduate counseling courses but had not yet taken a play therapy course.

Kao and Landreth (1997) utilized two instruments to assess change. The Play Therapy Attitude-Knowledge-Skills Survey (PTAKSS), an 88-item Likert scale format in which a 5 indicates high agreement or ability and a 1 indicates low agreement or ability, was used to measure change in child-centered attitudes, knowledge of child-centered play therapy, and confidence in applying child-centered play therapy skills. In addition, The California Psychological Inventory (CPI) was utilized to observe change in dominance and the intellectual efficiency of play therapists in training.

The treatment was a 3-semester hour graduate introduction to play therapy course taught once a week for 15 weeks for a total of 45 clock hours of training. Participants completed the PTAKSS and the CPI at the beginning and end of the semester. The pretest and posttest scores were paired and an analysis of covariance was computed to test the significance of the difference between the experimental and control group on the adjusted posttest mean scores for each hypotheses (Kao & Landreth, 1997).

The experimental group demonstrated a significantly higher mean score on the subscales of attitude, knowledge, and skills and a significantly higher mean total score on

the PTAKSS posttest than did the control group participants. The F ratios for the main effects were significant to the $< .0001$ level in attitude, knowledge, and skills. These scores indicated that the experimental group members attained a significant increase when compared to the control group in positive attitudes and beliefs towards children, in play therapy knowledge, and in confidence in applying play therapy skills as measured by the Play Therapy Attitude-Knowledge-Skills Survey. In addition, members of the experimental group reduced their tendency towards dominance and became less forceful and assuming. They showed a statistically significant reduction in dominance ($p < .05$) as measured by the CPI subscale score of Dominance. The results of this study showed that child-centered play therapy training helps increase beginning play therapists positive attitude toward children, play therapy knowledge, and their confidence in applying play therapy skills as well as reduce dominance tendencies (Kao & Landreth, 1997).

Homeyer and Rae (1998) conducted a study comparing the effectiveness of training for master's level graduate students in a 3-week, 5-week and 15-week play therapy course. The study was designed to determine the impact of

the length of training on student growth. The Play Therapy Attitude-Knowledge-Skills Survey (PTAKSS) was utilized to measure student growth in child-centered attitudes, knowledge about play therapy, and confidence in applying play therapy skills. The three treatment groups consisted of 12 students in the 3-week course, 8 students in the 5-week course, and 9 students in the 15-week course. A limitation of the study is that a control group was not used as a point of comparison for the three treatment groups. The three experimental groups participated in didactic classroom instruction, role play, observations of videotaped play therapy sessions and clinical experience with children. Members of the three experimental groups completed a PTAKSS pretest and posttest.

The researchers used a Paired Differences t-test to analyze the paired pretest and posttest scores for students within each group. The researchers wanted to determine if significant personal and professional growth occurred within each of the three semester lengths. The alpha level was set at .05 and the effect of 3-week, 5-week, and 15 week play therapy training was statistically significant for each subscale score with the exception the Attitude subscale score in the 5-week group.

Next, to determine if the length of semester training impacted student growth, an analysis of covariance was computed. The results indicated no significant difference among the three semester total scores on any of the subscale scores of the PTAKSS.

The results of these findings indicated that students experienced significant growth and development within the 3-week, 5-week, and 15-week semesters. In addition, the length of the semester did not influence the degree of student growth.

Play Therapy Supervision Models

Only two play therapy supervision models were found in the literature. The first model, is an intensive supervision/training model developed by Landreth at the Center for Play Therapy at the University of North Texas. Landreth's model provides the structure for a 3-day intensive play therapy practicum experience in individual and group play therapy and is not based on a specific theoretical model. Participants receive nine hours of supervision and training each day, for a total of 27 hours. Each supervision group is comprised of three play therapists and a supervisor. Each day begins with a 30-minute focus group, followed by each therapist facilitating

a 30-minute individual play therapy session and then receiving 30-minutes of feedback within the 3-person supervision group. A one-hour lunch break is followed by a second set of 30-minute group play therapy sessions and 30-minute feedback sessions. Afterwards, each small group receives one hour of informal supervision and training that includes a review of taped sessions, role-play, and other structured or process-oriented activities. During the last hour of the daily workshop, the four supervision groups of three play therapists each join together for a large-group impact session. During this session, participants receive instruction on topics such as ethics, child development, and therapeutic procedures. Play therapists reported increased self-awareness, self-confidence, skill development, and a more intensive understanding of the play therapy process. This model of utilizing a 30-minute play therapy session followed by a 30-minute feedback session has been utilized in conjunction with introductory play therapy courses and can be used during beginning practicum courses (Bratton, Landreth & Homeyer, 1993).

Brady and Friedrich (1982) developed a supervision model that addresses the developmental tasks within play, play therapy, and training. First, participants are

provided information that teaches the development process of play based upon Piaget's theory. Then, the developmental aspects of the play therapy relationship are discussed, and lastly, four specific levels of intervention are presented. The first level includes the physical presence of the play therapist that demonstrates interest, encouragement, and a manner of being with the child. The second level consists of reflecting and paraphrasing the child's statements. During the third level, third-person interpretations are made. An example of such an interpretation is: "Sometimes it makes children angry when they can't get their way." In the fourth level intervention, the therapist makes direct statements such as "You didn't like it that your father brought you late to the session." This model can be utilized to teach each level of intervention as a separate skill the play therapist can implement during play therapy sessions.

Conclusion

Play therapy requires specialized training that helps beginning play therapists integrate specific attitudes and skills that are not frequently taught in most adolescent or adult human services training programs (Landreth, 1991). The supervision process is critical to the development of

competent play therapists. Clinical supervision facilitates the play therapist's development of insight and knowledge about self, the child, and the therapeutic process (Guerney, 1983; Landreth, 1991).

Limited information is available about the process of play therapy supervision (Kranz & Lund, 1994). Additional research is needed to assist play therapy supervisors in facilitating the development of effective and therapeutic play therapists. This study was designed to determine the effects of the Child-Centered Self-Reflective Play Therapy Supervision Model on play therapy supervisees.

CHAPTER II

METHODS AND PROCEDURES

A pretest-posttest control group design was used to measure the development of play therapy supervisees that received supervision utilizing the child-centered self-reflective play therapy supervision model. Participants were comprised of master's level play therapy students who volunteered to participate in the study during the counseling practicum course. Participants during a spring semester counseling practicum were assigned to the control group and participants during a fall semester counseling practicum were assigned to the experimental group.

Definition of Terms

Clinical supervision is defined by Loganbill, Hardy, and Delworth (1982) as: "an intensive, interpersonally focused one-to-one relationship in which one person is designated to facilitate the development of therapeutic competence in the other person" (p. 4).

Play therapy is defined by Landreth (1991) as:

a dynamic interpersonal relationship between a child and a therapist trained in play therapy procedures who provides selected play materials and facilitates the

development of a safe relationship for the child to fully express and explore self (feelings, thoughts, experience, and behaviors) through the child's natural medium of communication, play. (p. 14)

Child-Centered Self-Reflective Play Therapy Supervision

Model is a 15-week structured self-reflective play therapy supervision model that encourages play therapy supervisees to become active participants in their development as counselors. The supervision model consists of a play therapy manual, play therapy workbook, and weekly supervision that includes the review of play therapy session videos.

1. The Play Therapy Manual reviews the philosophy and principles of child-centered play therapy. The manual also reviews rationale for the use of specific therapeutic responses.
2. The Play Therapy Workbook provides tools for supervisees to assess their own growth and development through reviewing videos, reflecting on the therapeutic process and completing self-assessment forms. In conjunction with reviewing their own weekly play therapy session videotapes, play therapy supervisees completed two self-assessment tools titled The Play Therapy Skills

Assessment (PTSA) and Play Therapy Counseling Skills.

These tools are designed to help play therapy supervisees develop a deeper understanding of the quality, effectiveness, and timing of their therapeutic responses.

3. Doctoral students in counselor education facilitated weekly play therapy supervision. The doctoral supervisors were specializing in play therapy and had received advanced training and supervision in play therapy. Their course work included Introduction to Play Therapy, Advanced Play Therapy, Group Play Therapy, and Filial Therapy. The supervisors utilized the Supervision Manual and the self-reflective supervision model developed for this study (Giordano, 1999).

The Child-Centered Self-Reflective Play Therapy Supervision Model was designed to enhance the play therapy supervisee's positive attitude and beliefs towards children, the play therapy supervisee's knowledge of the child-centered theoretical framework, and the effective application of clinical play therapy skills.

Skills refers to the ability of the play therapy supervisee to transfer play therapy knowledge into skills and the degree of confidence in applying those skills. For the purpose of this study, play therapy skills was

operationally defined as the score on the Skill subscale of the Play Therapy Attitude-Knowledge-Skills Survey.

Attitude refers to a set of child-centered beliefs the play therapy supervisee has integrated and observed in interactions which reflect a belief that children are unique, worthy of respect, have an inherent tendency toward growth and maturity, and are capable of positive self-direction (Landreth, 1991). For the purpose of this study, attitude was operationally defined as the score on the Attitude subscale of the Play Therapy Attitude-Knowledge-Skills Survey.

Knowledge includes the play therapy supervisee's understanding of child-centered theory, principles, and practice. For the purpose of this study, knowledge was operationally defined as the Knowledge subscale score of the Play Therapy Attitude-Knowledge-Skills Survey.

Tracking behavior is verbally responding to children's actions and non-verbal play. The play therapist states what is seen and observed. Tracking is used to help children feel the play therapy supervisee is interested in and understands their world (Landreth, 1991). For the purpose of this study, tracking behavior was operationally defined

as the score on the Tracking Behavior subscale of the Play Therapy Skills Assessment-Rater Assessment.

Reflecting content is verbally paraphrasing what the child has stated. Reflecting content lets children know that the play therapist hears what they are saying. It also validates children's perspective and clarifies children's understanding of self (Landreth, 1991). For the purpose of this study, reflecting content was operationally defined as the score on the Reflecting Content subscale of the Play Therapy Skills Assessment-Rater Assessment.

Reflecting feelings is verbally identifying and stating to children an emotion they are expressing. Reflecting children's feelings communicates acceptance of their feelings and needs. It also helps children learn to identify, understand, and verbally express their feelings (Landreth, 1991). For the purpose of this study, reflecting feelings was operationally defined as the score on the Reflecting Feelings subscale of the Play Therapy Skills Assessment-Rater Assessment.

Facilitating decision-making and self-responsibility is a process of returning responsibility. When children ask questions or seek assistance, the play therapy supervisee makes a response that encourages children to make their own

decisions and to take responsibility for a current concern. This assists children in developing self-responsibility (Landreth, 1991). For the purpose of this study, facilitating decision-making and self-responsibility was operationally defined as the score on the Facilitating Decision-Making and Self-Responsibility subscale of the Play Therapy Skills Assessment-Rater Assessment.

Facilitating esteem-building and encouragement is a therapeutic response that encourages children to accomplish an age-appropriate task without the assistance of an adult. This response also acknowledges children's efforts and helps children develop internal motivation and self-evaluation (Landreth, 1991). For the purpose of this study, facilitating esteem-building and encouragement was operationally defined as the score on the Facilitating Esteem-Building and Encouragement subscale of the Play Therapy Skills Assessment-Rater Assessment.

Encouraging the child to lead the process is a child-centered belief that children are capable of directing their own growth and actualization. Therapeutic responses that are encouraging provide opportunities for children to take responsibility for leading the process. This means that the play therapy supervisee does not make comments or

suggestions that direct children's play and does not ask children questions (Landreth, 1991). For the purpose of this study, encouraging the child to lead the process was operationally defined as the score on the Directed Child subscale of the Play Therapy Skills Assessment-Rater Assessment.

Set limits is a therapeutic response that acknowledges a child's feelings, communicates a limit, and targets an alternative behavior. For example, if a child wants to shoot the therapist with the dart gun the therapist would respond: I know you want to shoot me with the gun, but I am not for shooting. You can shoot the bop bag. Limits are communicated to protect the child, protect the therapist, protect the toys and room, structure the session, limit socially unacceptable behavior, and help the child learn self-control (Landreth, 1991). For the purpose of this study, set limits was operationally defined as the score on the Set Limits subscale of the Play Therapy Skills Assessment-Rater Assessment.

Therapist's congruence is the ability of the play therapist supervisee to use a tone of voice and facial expression that is congruent with the child's affect. In addition, the play therapy supervisee's tone of voice and facial

expression is also congruent with the play therapy supervisee's response (Landreth, 1991). For the purpose of this study, play therapy supervisee's congruence was operationally defined as the score on the Voice Incongruent subscale of the Play Therapy Skills Assessment-Rater Assessment.

Quality of non-verbal responses is the play therapy supervisee's ability to maintain an open body posture, to appear relaxed and comfortable, and to be interested in the child. For the purpose of this study, quality of non-verbal responses was operationally defined as the score on the Non-Verbal Response subscale of the Play Therapy Skills Assessment-Rater Assessment.

Quality of verbal responses includes the ability of the play therapist supervisee to make short, immediate and spontaneous therapeutic responses. These responses are also interactive and conversational and occur at a rate that enhances the therapeutic relationship. For the purpose of this study, quality of verbal responses was operationally defined as the score on the Voice is Mechanical or Rehearsed subscale of the Play Therapy Skills Assessment-Rater Assessment.

Hypotheses

To carry out the purpose of this study, the following hypotheses were formulated:

1. The experimental group will attain a significantly higher mean score on the Play Therapy Skills subscale of the Play Therapy Attitude-Knowledge-Skills Survey (PTAKSS) posttest than will the control group.
2. The experimental group will attain a significantly higher mean score on the Play Therapy Attitude subscale of the PTAKSS posttest than will the control group.
3. The experimental group will attain a significantly higher mean score on Play Therapy Knowledge subscale of the PTAKSS posttest than will the control group.
4. The experimental group will attain a significantly lower mean score on the Tracking Behavior subscale of the Play Therapy Skills Assessment (PTSA) posttest than will the control group.
5. The experimental group will attain a significantly lower mean score on the Reflecting Content subscale of the PTSA posttest than will the control group.
6. The experimental group will attain a significantly lower mean score on the Reflecting Feelings subscale of the PTSA posttest than will the control group.

7. The experimental group will attain a significantly lower mean score on the Facilitating Decision-Making and Self-Responsibility subscale of the PTSA posttest than will the control group.

8. The experimental group will attain a significantly lower mean score on the Facilitating Esteem-Building and Encouragement subscale of the PTSA posttest than will the control group.

9. The experimental group will attain a significantly lower mean score on the Directed the Child subscale of the PTSA posttest than will the control group.

10. The experimental group will attain a significantly lower mean score on the Setting Limits subscale of the PTSA posttest than will the control group.

11. The experimental group will attain a significantly lower mean score on the Voice is Incongruent subscale of the PTSA posttest than will the control group.

12. The experimental group will attain a significantly lower mean score on the Non-Verbal Responses subscale of the PTSA posttest than will the control group.

13. The experimental group will attain a significantly lower mean score on the Voice is Mechanical and Rehearsed subscale of the PTSA posttest than will the control group.

Instrumentation

Play Therapy Attitude-Knowledge-Skills Survey

The Play Therapy Attitude-Knowledge-Skills Survey (PTAKSS) is a self-administered written test developed by Kao and Landreth (1997) (See Appendix B). Beginning level master's play therapists need to accomplish three main objectives while receiving training in child-centered play therapy. These objectives were utilized when designing the subscales for the PTAKSS. The three subscales include the Attitude Scale, the Knowledge Scale, and the Skills Scale. Items in the attitude subscale (Items #1-#33) refer to essential beliefs and interaction patterns child-centered play therapists are expected to possess. Items in the knowledge subscale (Items #34-#54) refer to a knowledge of the theory, principles, and processes of child-centered play therapy. Items in the skill subscale (Items #55-#88) evaluate the level of the play therapist's confidence in applying skills. The PTAKSS is an 88-item survey that utilizes a Likert scale. The scale ranges from 5 indicating high agreement or ability to 1 indicating low agreement or ability.

Four expert judges with doctoral degrees in counseling who were considered experts in the field of play therapy

determined the content validity of the total scale and the three subscales. The mean scores of the four judges were total scale 4.66, attitude subscale 4.52, knowledge subscale 4.68, and skill subscale 4.78 (Kao & Landreth, 1997).

Field-testing was conducted on the entire PTAKSS. The sample group for the field test of the PTAKSS consisted of 104 graduate students who were majoring in counselor education with a specialty in child counseling. Reliability coefficients (Cronbach's alpha) for the PTAKSS were total scale .98, attitude scale .73, knowledge scale .94, and skill scale .99. A criteria validity test was calculated by using correlation coefficients. The correlation coefficients consisted of the number of graduate play therapy courses each participant had and their total score on the PTAKSS. The correlation coefficients were total scale .70 ($P < .0001$), attitude scale .34 ($P < .0001$), knowledge scale .71 ($P < .0001$), and skill scale .68 ($P < .0001$) (Kao & Landreth, 1997).

Play Therapy Skills Assessment

The Play Therapy Skills Assessment-Rater Assessment (Giordano, 1999) is a 10-item assessment modified by the author from a previous assessment titled the Play Therapy

Skills Checklist. The Play Therapy Skills Checklist was developed during a three-year period by Garry Landreth and Sue Bratton professors in the Counseling, Development, and Higher Education Department at the University of North Texas, Denton and Linda Homeyer professor in the Department of Educational Administration and Psychological Services at Southwest Texas State University, San Marcos. They conducted a review of the play therapy literature to determine specific types of therapeutic responses utilized by child-centered play therapists. These responses included: tracking behavior, reflecting content, reflecting feeling, facilitating decision-making and responsibility, facilitating creativity and spontaneity, facilitating esteem-building and encouraging, and enlarging the meaning/facilitating understanding. Next, items were developed to encourage reflection on the quality of the play therapist's verbal and non-verbal responses. These items included: succinct/interactive, rate of responses, leaned forward/open, relaxed/comfortable, appeared interested, tone and expression of therapist was congruent with child's affect, and tone and expression of therapist was congruent with therapist's response. Lastly, an area for the supervisor's comments was created to provide

feedback in areas such as: limit setting, immediacy/spontaneity, child made contact/connectedness, identified themes, therapist's strengths, and areas for growth. The checklist contained a scale that asked the evaluator to rate each skill as being appropriate, having too much, needing more, or missing. The Play Therapy Skills Checklist was utilized in the Introduction to Play Therapy course, Advanced Play Therapy course and in the master's and doctoral practicum courses for self-assessment, peer supervision, and by play therapy supervisors. After receiving feedback from classes and play therapy supervisees, the form was restructured and additional items were added including conveyed understanding of child's world and facilitated child's understanding of self. This checklist contained a Likert scale to rate specific therapeutic skills and abilities. The scale ranged from 1 (very undeveloped skills) to 5 (highly developed skills).

The author made a third revision to the Play Therapy Skills Checklist and developed three assessment forms. The first form titled The Play Therapy Skills Assessment was developed to be utilized by the play therapy supervisee and supervisor as a feedback tool to increase awareness of skill development. This assessment utilizes a Likert scale

to evaluate the development of each skill. The Likert scale rates the implementation of the skill from a range of 1 (undeveloped skills) to 5 (developed skills). Each item is a specific behavior that is implemented by an effective play therapist.

A second assessment form, Play Therapy Counseling Skills was developed by the author for play therapy supervisees to utilize while reviewing videos of their play therapy sessions. This form helps the play therapy supervisee identify the type of therapeutic responses made, the quality of the responses, the quality of non-verbal responses, the level of connection with the child, and the congruence in their verbal and non-verbal responses.

A third assessment, the Play Therapy Skills Assessment-Rater Assessment (See Appendix C) was designed by the author to document behavioral observations of the skills of the play therapy supervisees. This form was used to analyze the level of skill improvement between the pretest and posttest play therapy session videos for the experimental and control groups. The Play Therapy Skills Assessment (PTSA) is a behavioral observation instrument that reports the number of times a skill was implemented ineffectively or the number of times it was omitted when

the opportunity was present. For example, if a child threw a toy at the two-way mirror and the play therapist did not set a limit, the rater marked missed opportunity to set a limit. Later in the session, if the play therapist attempted to set the limit, but did not follow the three-step ACT model, the rater made an additional tally mark on the subscale of limit setting. The larger the score for each therapeutic skill, the less effective the play therapist was in implementing the specific skill. Therefore, a decreasing score on this instrument from the pretest to the posttest indicates improvement in applying the therapeutic skill.

Four video raters were randomly assigned videotapes from the experimental and control groups' pre and post play therapy session videos. The video raters viewed the play therapy session video in its entirety and documented behavioral observations of the play therapy supervisees' skills in the pretest and posttest videotapes. The Play Therapy Skills Assessment-Rater Assessment evaluates the skills of tracked behavior, reflected content, reflected feelings, facilitated esteem-building, facilitated decision-making and returned responsibility, set limits,

directed the child, voice incongruent, quality of nonverbal responses and quality of verbal responses (See Appendix C).

Selection of Participants

Play therapy graduate students who completed the introduction to play therapy course and were enrolled in counseling practicum courses during the spring 1999 and fall 1999 semesters at the University of North Texas were asked to volunteer to participate in this study. Completion of all required Counselor Education course work, with the exception of internship, is a prerequisite to enroll in the counseling practicum. This is the first course in the master's degree program that requires students to counsel actual clients.

Participants were asked to sign an informed consent which explained they had the right to withdraw from the study at any time and that completed assessments and surveys would not influence their course grade (Appendix A). All surveys, assessments, and videos were anonymously coded by the researcher and remained confidential. Play therapy graduate students who chose to participate during the spring 1999 semester were assigned to the control group. Play therapy supervisees in the fall 1999 practicum course that chose to participate in the study were assigned

to the experimental group. A total of 30 participants (15 experimental and 15 control) completed the PTAKSS pre and posttest. One participant in the control group did not complete three items in the section of the PTAKSS that comprised the Skills subscale. Therefore, only 29 participants were used to measure change on the Skills subscale.

In addition, all 30 participants submitted a pre and post play therapy session videotape. After reviewing each play therapy session video, the video raters reported on the PTSA that there was no opportunity to observe specific skills for several participants. For example, if a child did not behave in a manner that required limit setting, the video rater had no opportunity to observe the play therapy supervisee's ability to use this therapeutic response. Therefore, a minimum of 26 participants and a maximum of 30 participants were utilized to calculate differences between the posttest means for specific skills on the Play Therapy Skills Assessment-Rater Assessment.

Collection of the Data

During the initial informational meeting, graduate student volunteers received an explanation of the procedures involved in this study. After they read the

cover letter and signed the informed consent form, they were asked to complete the Play Therapy Attitude-Knowledge-Skills Survey. This instrument provided a score of each participant's beginning level of knowledge, child-centered attitude, and their confidence in transferring their knowledge of play therapy into therapeutic skills. This instrument was coded and remained confidential. It was re-administered at the end of the semester. A videotape of the first and one of the final eighth through the tenth (end of the semester) play therapy sessions were coded and kept until January of 2000 at which time all of the videotapes were rated blindly by four play therapy doctoral students. The raters used the Play Therapy Skills Assessment-Rater Assessment to evaluate each of the videotapes. The tapes were erased at the conclusion of the rating.

Procedures

After completing the PTAKSS pretest, play therapy supervisees in the experimental group participated in a fifteen-week supervised play therapy practicum that utilized the Child-Centered Self-Reflective Play Therapy Supervision Model. Both the experimental and control groups received weekly supervision from a doctoral supervisor. The graduate play therapy supervisees in the experimental and

control groups received either weekly live supervision or weekly individual supervision at a designated time outside of the practicum hours. The play therapy supervisors of the control group did not utilize the Self-Reflective Play Therapy Supervision Model.

Module 1

During the first supervision meeting, participants were given a copy of the Play Therapy Manual and workbook that is part of the Self-Reflective Play Therapy Supervision Model. The manual provided a review of the main therapeutic responses used in child-centered play therapy and provided weekly self-assessment forms to be utilized while supervisees reviewed play therapy session videos. The play therapy supervisor facilitated a discussion about the purpose and structure of play therapy supervision. Participants discussed their goals and expectations of play therapy supervision. Then, the participants read pages 10-12 of the Play Therapy Manual that discussed parent consultation. Next, the supervisor demonstrated the role of the play therapist in a parent consultation. After discussing play therapy supervisees questions and concerns, the supervisees role played the parent consultation in

dyads. Supervisees were asked to read pages 6-24 of the play therapy manual for the next week.

Module 2

Prior to the second session, participants read the play therapy manual to learn about the principles and goals of child-centered play therapy, and how to create a therapeutic environment, facilitate understanding of the child's world and facilitate the child's understanding of self. Afterwards, participants watched Garry Landreth's child-centered play therapy video in order to review the implementation of the therapeutic skills of tracking behavior, reflecting content, reflecting feelings, and facilitating decision-making. Participants completed "Identifying Therapeutic Responses Part 1" while watching the video. Next, participants completed a paragraph journal entry that asked them to reflect on their interest, concerns, and reservations about being a play therapist. Lastly, participants reviewed the section of the Play Therapy Manual that discusses tracking behavior, reflecting content, reflecting feelings, and facilitating decision-making. After each skill was reviewed through reading and discussion, the play therapy supervisees role played each skill in dyads.

Module 3

During the initial part of this supervisory session, play therapy supervisees reviewed Garry Landreth's child-centered play therapy video in order to learn how to implement the therapeutic skills of facilitating esteem-building, facilitating creativity and spontaneity, and setting limits. After reviewing the video, participants completed the worksheet titled "Identifying Therapeutic Responses Part 2". Afterwards, participants completed a paragraph journal entry about how play therapy might impact the child's life.

Lastly, participants reviewed the section of the Play Therapy Manual that discusses esteem-building and encouraging, setting limits, and creativity and spontaneity. After each skill was reviewed through reading and discussion, the play therapist supervisees role played each skill in dyads.

Module 4

Prior to the supervisory meeting, participants reviewed their own first play therapy session video and completed the "Play Therapy Assessment of Therapeutic Skills - Video 1" while watching their video. The participants reflected on their ability to apply the

therapeutic responses of tracking behavior, reflecting content, reflecting feelings, and facilitating decision-making and responsibility. Then, participants completed a paragraph journal entry that asked them to reflect on their understanding and ability to apply the skills listed above. During supervision, play therapy supervisees played a segment of their session videotape in order to receive feedback from their peers and supervisors.

Module 5

During this week, participants completed the "Play Therapy Assessment of Therapeutic Responses - Video 2" while watching the video of their second play therapy session. Participants analyzed and reflected upon their ability to refrain from asking the child questions, making comments and suggestions that direct the child, making statements that praise or judge the child, and inappropriately helping the child. Then, participants completed a paragraph journal entry that asked them to reflect on how providing an environment in which the child leads might impact the child's life. During supervision, play therapy supervisees played a segment of their session videotape in order to receive feedback from their peers and supervisors.

Module 6

Participants reviewed their third play therapy session video and completed the "Play Therapy Skills - Video 3" while watching their video. The participants reflected on their ability to apply the therapeutic responses of facilitating esteem-building and making encouraging comments, facilitating creativity and spontaneity and conveying an understanding of the child's world.

Participants also evaluated their ability to set limits for the purpose of protecting the child, therapist, toys, or room and to provide structure to the therapeutic process. Then, participants completed a paragraph journal entry that asked them to reflect on their understanding and ability to apply the skill of setting limits. During supervision, play therapy supervisees played a segment of their session videotape in order to receive feedback from their peers and supervisors.

MODULE 7

During this week, participants completed the "Play Therapy Assessment of Therapeutic Responses - Video 4" while watching the video of their fourth play therapy session. Participants analyzed and reflected upon their ability to appropriately answer children's questions,

facilitate the child's understanding of self, enlarge the meaning, and to avoid missing opportunities to reflect a feeling. Then, participants completed a paragraph journal entry that asked them to reflect on their understanding and ability to apply the skill of "enlarging the meaning." During supervision, play therapy supervisees played a segment of their session videotape in order to receive feedback from their peers and supervisors.

MODULES 8,10,12

Participants completed the "Play Therapy Counseling Skills" form by analyzing twenty of their own therapeutic responses. First, they determined which one of the sixteen responses were utilized. After completing this section, they evaluated the quality of their response, the appropriateness of their nonverbal communication, and their connection with the child. Then, they assessed the congruence between their tone and facial expression and the child's affect as well as the congruence between their tone and facial expression and their own response. Participants completed this form in modules 8,10, and 12. Lastly, participants wrote a one paragraph journal entry with each module. During supervision, play therapy supervisees played

a segment of their session videotape in order to receive feedback from their peers and supervisors.

MODULES 9,11,13

Participants utilized the "Play Therapy Assessment of Therapeutic Skills" to identify and change 8 responses they wanted to make more therapeutic. First, while reviewing their play therapy session video, participants identified a therapeutic response they wished could be changed. Next, the participants used the assessment form to write the child's response, then the participants' actual response, and lastly the participants wrote another response (the corrected response) they would like to have used.

Participants completed this form for modules 9, 11, and 13. Then, participants completed a paragraph journal entry that asked them to reflect on the rationale behind changing their response. During supervision, play therapy supervisees played a segment of their session videotape in order to receive feedback from their peers and supervisors.

Module 14

Play therapy supervisees completed the Play Therapy Skills Assessment-Self Assessment and the Play Therapy Attitude-Knowledge-Skills Survey. They wrote their journal entry

that asked them to list three goals to further their development and skills in play therapy.

Module 15

Participants completed the last journal entry that requested feedback regarding their experience utilizing the Self-Reflective Play Therapy Supervision Model.

Data Analysis

Objective Rater Reliability

The interrater reliability of the Play Therapy Skills Assessment-Rater Assessment was established three separate times. At the end of the first training session, raters scored sample play therapy sessions blindly to establish reliability. Intraclass correlation coefficient was used since Tinsley and Weiss (1975) recommended the intraclass correlation (R) as the best measure of interrater reliability available for ordinal and interval level measurement. The initial coefficient for the first session was calculated at $R = .94$. Following this training session, the video raters individually rated five play therapy session videotapes. Video raters returned the rated videos and utilized video segments from their first rating for training purposes. At the end of the second training session, video raters scored two play sessions blindly to

ensure continued rater reliability. The coefficient for the second session was calculated at $R = .92$. Participants received a second set of five play therapy session videos, rated them individually and returned for a third training session. At the end of third training, interrater reliability was calculated at $R = .83$. Video raters were given the last set of five videos to rate individually.

PTAKSS

The effectiveness of the Child-Centered Self-Reflective Play Therapy Supervision Model was determined by observing measured changes in knowledge of child-centered play therapy, confidence in applying play therapy skills, and child-centered attitude. The pretest and posttest responses were coded and entered as data into SPSS. An ANCOVA was calculated to test the significance of difference between the experimental and control groups on the adjusted posttest mean scores for each hypothesis. For each subscale score, the PTAKSS posttest scores were used as the dependent variable and the PTAKSS pretest scores were used as the covariate. ANCOVA was used to adjust the group mean in the posttest on the basis of the pretest. The significance of difference between the means was tested at

the .05 level. On the basis of ANCOVA, the hypotheses were either retained or rejected.

PTSA

The effectiveness of the Child-Centered Self-Reflective Play Therapy Supervision Model was also determined by observing measured changes in the supervisees skill development as observed on their pre and post play therapy session videos. Four doctoral students with advanced play therapy training and supervision rated the play therapy session videos. The data was entered into SPSS and an ANCOVA was calculated to test the significance of the difference between the experimental and control groups on the adjusted posttest means for each of the hypotheses that addressed skill development. When analyzing each therapeutic skill, the posttest mean score was used as the dependent variable and the pretest score was the covariate. ANCOVA was used to adjust the group means in the posttest on the basis of the pretest. As a result, the experimental and control groups were statistically equated. Significance of difference between the means was tested at the .05 level. On the basis of ANCOVA, the hypotheses were either rejected or not rejected.

CHAPTER III

RESULTS AND DISCUSSION

This chapter presents the results of the analysis of data for each hypothesis tested and significant findings on the instrument subscales. Results of each hypothesis are discussed as well as implications and recommendations for further research.

Results

An analysis of covariance (ANCOVA) was used to analyze the effectiveness of a child-centered self-reflective play therapy supervision model. ANCOVA, which combines regression analysis and analysis of variance, is used to adjust for preexisting differences between the experimental and control group. Since the experimental and control groups were intact groups that were unable to be randomly assigned, an Analysis of Covariance (ANCOVA) was used to reduce the error variance. ANCOVA is an appropriate method of analysis if the differences among the groups on the covariate is small and there is no interaction between the covariate and the treatment (Hinkle, Wiersma & Jurs, 1998).

If the assumption of homogeneity of variance for ANCOVA was not met, an alternative independent t-test utilizing the gain score as the dependent variable was performed. The results of this study are presented in the order that the hypotheses were tested. A level of significance of .05 was established to either retain or reject the hypotheses.

PTAKSS

Three one-way between-subjects analysis of covariance (ANCOVA) were utilized to analyze the difference between the experimental and control group on the PTAKSS subscales of confidence in applying skills, child-centered attitude and knowledge of child-centered play therapy. Covariates were the pretest scores on the PTAKSS and the dependent variables were the posttest scores. The ANCOVA tested if the group mean scores on the posttest subscale scores of skills, attitude and knowledge, that were adjusted for differences on the pretest means, were the same for the experimental and control group.

The experimental and the control group were each comprised of 15 participants. However, if a participant failed to complete three or more items on a specific subscale of the PTAKSS, the score was omitted from the

total sample used to calculate the ANCOVA. The PTAKSS subscale scores of one control group participant were omitted when calculating the ANCOVA for the subscale of confidence in applying skills, hypothesis 1.

In addition, the pretest subscale scores for both the experimental and control groups were high and ranged between 3.6 - 4.1 on a five point scale. As a result, there was decreased opportunity for noticeable improvement on the three subscale scores.

Hypothesis 1

The experimental group will attain a significantly higher mean score on the Play Therapy Skills subscale of the Play Therapy Attitude-Knowledge-Skills Survey (PTAKSS) posttest than will the control group.

Table 1 presents the pre and posttest means and standard deviations for the experimental and control groups. Table 2 presents the analysis of covariance data showing that there was no significant difference between the posttest mean scores of the experimental and control groups.

Table 1

Mean scores on the PTAKSS Skills subscale

	Experimental (n=15)		Control (n=14)	
	Pretest	Posttest	Pretest	Posttest
Mean	3.5588	4.1078	3.7824	4.2584
SD	.2865	.4066	.2326	.8230
Total Cases = 29				

Table 2

Analysis of covariance for the PTAKSS Skills subscale

Source	SS	df	Mean Square	F	Sig.	Eta Squared
Covariates	2.056	1	2.056	5.899	.002	.185
Main Effects	.058	1	.058	.166	.687	.006
Error	9.063	26	.349			
Total Cases = 29						

Table 2 shows the F ratio for the main effects was not significant at the <.05 level indicating that there was not a statistically significant difference between the experimental and the control group's Play Therapy Skills

subscale score of the PTAKSS. On the basis of this data, hypothesis 1 was not rejected.

Hypothesis 2

The experimental group will attain a significantly higher mean score on the Play Therapy Attitude subscale of the PTAKSS posttest than will the control group.

Table 3 presents the pre and posttest means and standard deviations for the experimental and control groups. Table 4 presents the analysis of covariance data showing that there was no significant difference between the posttest mean scores of the experimental and control groups.

Table 3

Mean scores on the PTAKSS Attitude subscale

	Experimental (n=15)		Control (n=15)	
	Pretest	Posttest	Pretest	Posttest
Mean	3.8404	3.9111	3.8444	3.9091
SD	.2153	.2281	.1388	.1260
Total Cases = 30				

Table 4

Analysis of covariance for the PTAKSS Attitude subscale

Source	SS	df	Mean Square	F	Sig.	Eta Squared
Covariates	.208	1	.208	7.572	.010	.219
Main Effects	.0001	1	.0001	.004	.949	.000
Error	.742	27	.027			
Total Cases = 30						

Table 4 shows the F ratio for the main effects was not significant at the $<.05$ level indicating that there was not a statistically significant difference between the experimental and control group's Play Therapy Attitude subscale score of the PTAKSS. On the basis of this data, hypothesis 2 was not rejected.

Hypothesis 3

The experimental group will attain a significantly higher mean score on the Play Therapy Knowledge subscale of the PTAKSS posttest than will the control group.

Table 5 presents the pre and posttest means and standard deviations for the experimental and control groups. Table 6 presents the analysis of covariance data

showing that there was no significant difference between the posttest mean scores of the experimental and control groups.

Table 5

Mean scores on the PTAKSS Knowledge subscale

	Experimental (n=15)		Control (n=15)	
	Pretest	Posttest	Pretest	Posttest
Mean	4.1016	4.2032	3.9365	4.0984
SD	.7355	.2623	.2804	.2315
Total Cases = 30				

Table 6

Analysis of covariance for the PTAKSS Knowledge subscale

Source	SS	df	Mean Square	F	Sig.	Eta Squared
Covariates	.272	1	.272	5.083	.032	.158
Main Effects	.042	1	.042	.783	.384	.028
Error	1.442	27	.053			
Total Cases = 30						

Table 6 shows the F ratio for the main effects was not significant at the $<.05$ level indicating that there was not a statistically significant difference between the experimental and control group's Play Therapy Knowledge subscale score of the PTAKSS. On the basis of this data, hypothesis 3 was not rejected.

PTSA

The Play Therapy Skills Assessment (PTSA) is a behavioral observation instrument that reports the number of times a skill was implemented ineffectively or the number of times it was omitted when the opportunity was present. The larger the score for each therapeutic skill, the less effective the play therapist was in implementing the specific skill. Therefore, a decreasing score on this instrument from the pretest to the posttest indicates improvement in applying the therapeutic skill. The experimental and the control group were each comprised of 15 participants. However, if the play therapist supervisee did not have an opportunity to utilize a specific therapeutic skill, the video rater did not assign a numerical value to the skill. Therefore, when the participant did not have a score for a specific therapeutic response, the participant was not included as a member of

the experimental or control group in the statistical analysis.

Hypothesis 4

The experimental group will attain a significantly lower mean score on the Tracking Behavior subscale of the PTSA posttest than will the control group.

Table 7 presents the pre and posttest means and standard deviations for the experimental and control groups. Since the assumption of homogeneity of variance was violated, an ANCOVA was not used to measure the difference between the posttest mean scores of the experimental and control group. Instead, an independent t-test utilizing the gain score as the dependent variable was calculated to determine the difference between the average gain scores for the experimental and control group. Table 8 presents the mean scores, standard deviations and standard error mean for the experimental and control groups. Table 9 presents the Levene's test for Equality of Variances and statistics for the pooled-variance t-test (used for equal variances assumed) and the separate variance t-test (used for equal variances not assumed). Table 9 shows a significant difference between the average gain scores for the supervisees in the experimental and control groups.

Table 7

Mean scores on the PTSA Tracking Behavior subscale

	Experimental (n=15)		Control (n=15)	
	Pretest	Posttest	Pretest	Posttest
Mean	4.6667	1.4000	6.6667	9.2000
SD	6.6512	.8281	5.2735	8.4448
Total Cases = 30				

Table 8

Average gains of supervisees on the PTSA Tracking Behavior
posttest subscale, classified according to the pretest
subscale

	N	Mean	Standard Deviation	Std. Error Mean
Experimental	15	-3.2667	6.4749	1.6718
Control	15	2.5333	8.9432	2.3091
Total Cases = 30				

Table 9

Analysis of t-test for equality of mean scores on the PTSATracking Behavior subscale

		Equal variances assumed	Equal variances not assumed
Levene's Test for Equality of Variances	F	1.012	
	Sig.	.323	
T-Test for Equality of Means	t	-2.035	-2.035
	df	28.000	25.513
	Sig. (2-tailed)	.051	.052
	Mean Difference	-5.800	-5.800
	Standard Error Difference	2.851	2.851

Table 9 shows that the assumption of equal variances was not violated. Therefore, the Equal variances assumed t-test results were used. The results show a statistically significant difference at the $<.05$ level ($t = -2.035$ with 28 degrees of freedom and significance $< .051$) indicating that there was a statistically significant difference in the experimental and control group's average gain scores

on the Tracking Behavior subscale of the PTSA. On the basis of this data, hypothesis 4 was rejected.

Hypothesis 5

The experimental group will attain a significantly lower mean score on the Reflecting Content subscale of the PTSA posttest than will the control group.

Table 10 presents the pre and posttest means and standard deviations for the experimental and control groups. Table 11 presents the analysis of covariance data showing that there was no significant difference between the posttest mean scores of the experimental and control groups.

Table 10

Mean scores on the PTSA Reflecting Content subscale

	Experimental (n=14)		Control (n=14)	
	Pretest	Posttest	Pretest	Posttest
Mean	8.4667	2.9286	5.2857	6.9333
SD	6.0222	1.9400	4.0082	12.1271
Total Cases = 28				

Table 11

Analysis of covariance for the PTSA Reflecting Content subscale

Source	SS	df	Mean Square	F	Sig.	Eta Squared
Covariates	284.396	1	284.396	4.012	.056	.138
Main Effects	265.604	1	265.604	3.747	.064	.130
Error	1771.961	25	70.878			
Total Cases = 28						

Table 11 shows the F ratio for the main effects was not significant at the $<.05$ level indicating that there was not a statistically significant difference between the experimental and control group's mean score on the Reflecting Content subscale of the PTSA posttest. On the basis of this data, hypothesis 5 was not rejected.

Hypothesis 6

The experimental group will attain a significantly lower mean score on the Reflecting Feelings subscale of the PTSA posttest than will the control group.

Table 12 presents the pre and posttest means and standard deviations for the experimental and control

groups. Table 13 presents the analysis of covariance data showing that there was no significant difference between the posttest mean scores of the experimental and control groups.

Table 12

Mean scores on the PTSA Reflecting Feelings subscale

	Experimental (n=15)		Control (n=15)	
	Pretest	Posttest	Pretest	Posttest
Mean	4.4667	2.8667	3.6000	4.7333
SD	2.9244	1.9223	1.9567	3.5349
Total Cases = 30				

Table 13

Analysis of covariance for the PTSA Reflecting Feelings subscale

Source	SS	df	Mean Square	F	Sig.	Eta Squared
Covariates	.041	1	.041	.005	.945	.000
Main Effects	24.950	1	24.950	2.973	.096	.099
Error	226.626	27	8.394			
Total Cases = 30						

Table 13 shows the F ratio for the main effects was not significant at the $<.05$ level indicating that there was not a statistically significant difference between the experimental and control group's mean score on Reflecting Feelings subscale of the PTSA posttest. On the basis of this data, hypothesis 6 was not rejected.

Hypothesis 7

The experimental group will attain a significantly lower mean score on the Facilitating Decision-Making and Self-Responsibility subscale of the PTSA posttest than will the control group. Table 14 presents the pre and posttest means and standard deviations for the experimental and control groups.

Table 14

Mean scores on the PTSA Facilitated Decision-Making and Self-Responsibility subscale

	Experimental (n=14)		Control (n=14)	
	Pretest	Posttest	Pretest	Posttest
Mean	5.6429	1.6667	2.7857	1.8667
SD	4.7492	1.9518	2.4236	3.2042
Total Cases = 28				

Since the assumption of homogeneity of variance was violated, an ANCOVA was not used to measure the difference between the posttest mean scores of the experimental and control group. Instead, an independent t-test utilizing the gain score as the dependent variable was calculated to determine the difference between the average gain scores for supervisees in the experimental and control group. Table 15 presents the mean scores, standard deviations and standard error mean for the experimental and control groups.

Table 15

Average gains of supervisees on the PTSA Facilitating Decision-Making and Self-Responsibility posttest subscale, classified according to the pretest subscale

	N	Mean	Standard Deviation	Std. Error Mean
Experimental	14	-4.0000	3.1865	.8516
Control	14	-.7857	3.5772	.9561
Total Cases = 28				

Table 16 presents the Levene's test for Equality of Variances and statistics for the pooled-variance t-test (used for equal variances assumed) and the separate variance t-test (used for equal variances not assumed). Table 16 shows a significant difference between the average gain scores for supervisees in the experimental and control groups.

Table 16

Analysis of t-test for equality of mean scores on the PTSA
Facilitating Decision-Making and Self-Responsibility
subscale

		Equal variances assumed	Equal variances not assumed
Levene's Test for Equality of Variances	F	.049	
	Sig.	.827	
T-Test for Equality of Means	t	-2.510	-2.510
	df	26.000	25.660
	Sig. (2-tailed)	.019	.019
	Mean Difference	-3.214	-3.214
	Standard Error Difference	1.280	1.280

Table 16 shows that the assumption of equal variances was not violated. Therefore, the Equal variances assumed t-test results were used. The results show a statistically significant difference at the $<.05$ level ($t = -2.510$ with 26 degrees of freedom and significance $< .019$) indicating a statistically significant difference in the experimental and control group's average gain scores on the Facilitating Decision-Making and Self-Responsibility subscale of the PTSA. On the basis of this data, hypothesis 7 was not rejected.

Hypothesis 8

The experimental group will attain a significantly lower mean score on the Facilitating Esteem-Building and Encouragement subscale of the PTSA posttest than will the control group.

Table 17 presents the pre and posttest means and standard deviations for the experimental and control groups. Since the assumption of homogeneity of variance was violated, an ANCOVA was not used. Instead, an independent t-test utilizing the gain score as the dependent variable was calculated to determine the difference between the average gain scores for supervisees in the experimental and control group. Table 18 presents the mean scores, standard

deviations and standard error mean for the experimental and control groups.

Table 17

Mean scores on the PTSA Facilitated Esteem-Building and Encouragement subscale

	Experimental (n=15)		Control (n=14)	
	Pretest	Posttest	Pretest	Posttest
Mean	3.3333	1.0000	1.5000	2.3333
SD	2.6095	1.0690	1.2860	3.0394
Total Cases = 29				

Table 18

Average gains of supervisees on the PTSA Facilitating Esteem-Building and Encouragement posttest subscale, classified according to the pretest subscale

	N	Mean	Standard Deviation	Std. Error Mean
Experimental	15	-2.3333	2.6095	.6738
Control	14	1.0000	3.3968	.9078
Total Cases = 29				

Table 19 presents the Levene's test for Equality of Variances and statistics for the pooled-variance t-test (used for equal variances assumed) and the separate variance t-test (used for equal variances not assumed). Table 19 shows a significant difference between the average gain scores for the experimental and control groups.

Table 19

Analysis of t-test for equality of mean scores on the PTSA Facilitating Esteem-Building and Encouragement subscale

		Equal variances assumed	Equal variances not assumed
Levene's Test for Equality of Variances	F	.303	
	Sig.	.587	
T-Test for Equality of Means	t	-2.976	-2.948
	df	27.000	24.393
	Sig. (2-tailed)	.006	.007
	Mean Difference	-3.333	-3.333
	Standard Error Difference	1.120	1.120

Table 19 shows that the assumption of equal variances was not violated. Therefore, the Equal variances assumed

t-test results were used. The results show a statistically significant difference at the $<.05$ level ($t = -2.976$ with 27 degrees of freedom and significance $< .006$) indicating a statistically significant difference between the experimental and control group's average gain scores on the Facilitating Esteem-Building and Encouragement subscale of the PTSA. On the basis of this data, hypothesis 8 was not rejected.

Hypothesis 9

The experimental group will attain a significantly lower mean score on the Directed the Child subscale of the PTSA posttest than will the control group.

Table 20 presents the pre and posttest means and standard deviations for the experimental and control groups. Table 21 presents the analysis of covariance data showing that there was no significant difference between the posttest mean scores of the experimental and control groups.

Table 20

Mean scores on the PTSA Directed the Child subscale

	Experimental (n=15)		Control (n=15)	
	Pretest	Posttest	Pretest	Posttest
Mean	4.4667	1.8000	4.6000	2.8000
SD	4.4056	2.3664	3.2907	4.3622
Total Cases = 30				

Table 21

Analysis of covariance for the PTSA Directed the Child subscale

Source	SS	df	Mean Square	F	Sig.	Eta Squared
Covariates	92.795	1	92.795	9.942	.004	.269
Main Effects	6.591	1	6.591	.706	.408	.025
Error	252.005	27	9.334			
Total Cases = 30						

Table 21 shows the F ratio for the main effects was not significant at the $<.05$ level indicating that there was not a statistically significant difference between the

experimental and control group's mean score on the Directed the Child subscale of the PTSA posttest. On the basis of this data, hypothesis 9 was rejected.

Hypothesis 10

The experimental group will attain a significantly lower mean score on the Setting Limits subscale of the PTSA posttest than will the control group.

Table 22 presents the pre and posttest means and standard deviations for the experimental and control groups. Table 23 presents the analysis of covariance data showing that there was no significant difference between the posttest mean scores of the experimental and control groups.

Table 22

Mean scores on the PTSA Setting Limits subscale

	Experimental (n=13)		Control (n=13)	
	Pretest	Posttest	Pretest	Posttest
Mean	5.7143	1.7857	2.2143	2.4286
SD	6.8884	2.6941	2.4551	3.2276
Total Cases = 26				

Table 23

Analysis of covariance for the PTSA Setting Limits subscale

Source	SS	df	Mean Square	F	Sig.	Eta Squared
Covariates	27.836	1	27.836	3.238	.085	.123
Main Effects	11.215	1	11.215	1.305	.265	.054
Error	197.702	23	8.596			
Total Cases = 26						

Table 23 shows the F ratio for the main effects was not significant at the $<.05$ level indicating that there was not a statistically significant difference between the experimental and control group's mean score on the Setting Limits subscale of the PTSA posttest. On the basis of this data, hypothesis 10 was rejected.

Hypothesis 11

The experimental group will attain a significantly lower mean score on the Voice Incongruent subscale of the PTSA posttest than will the control group.

Table 24 presents the pre and posttest means and standard deviations for the experimental and control groups. Table 25 presents the analysis of covariance data

showing that there was no significant difference between the posttest mean scores of the experimental and control groups.

Table 24

Mean scores on the PTSA Voice Incongruent subscale

	Experimental (n=15)		Control (n=15)	
	Pretest	Posttest	Pretest	Posttest
Mean	4.6667	1.6667	1.8000	2.8000
SD	5.7900	2.8200	2.2104	4.2628
Total Cases = 30				

Table 25

Analysis of covariance for the PTSA Voice Incongruent subscale

Source	SS	df	Mean Square	F	Sig.	Eta Squared
Covariates	27.558	1	27.558	2.200	.150	.07
Main Effects	21.374	1	21.374	1.707	.202	.059
Error	338.175	27	12.525			
Total Cases = 30						

Table 25 shows the F ratio for the main effects was not significant at the $<.05$ level indicating that there was not a statistically significant difference between the experimental and control group's mean score on the Voice Incongruent subscale of the PTSA posttest. On the basis of this data, hypothesis 11 was rejected.

Hypothesis 12

The experimental group will attain a significantly lower mean score on the Non-Verbal Responses subscale of the PTSA posttest than will the control group.

Table 26 presents the pre and posttest means and standard deviations for the experimental and control groups.

Table 26

Mean scores on the PTSA Non-Verbal Responses subscale

	Experimental (n=15)		Control (n=15)	
	Pretest	Posttest	Pretest	Posttest
Mean	1.4000	.7333	.7333	.8000
SD	1.8048	1.1629	1.2799	1.2071
Total Cases = 30				

Table 27 presents the analysis of covariance data showing that there was no significant difference between the posttest mean scores of the experimental and control groups.

Table 27

Analysis of covariance for the PTSA Non-Verbal Responses subscale

Source	SS	df	Mean Square	F	Sig.	Eta Squared
Covariates	.561	1	.561	5.083	.391	.014
Main Effects	.0002	1	.0002	.000	.989	.122
Error	3146.259	27	116.528			
Total Cases = 30						

Table 27 shows the F ratio for the main effects was not significant at the <.05 level indicating that there was not a statistically significant difference between the experimental and control group's mean score on the Non-Verbal Responses subscale of the PTSA posttest. On the basis of this data, hypothesis 12 was rejected.

Hypothesis 13

The experimental group will attain a significantly lower mean score on the Verbal Responses subscale of the PTSA posttest than will the control group.

Table 28 presents the pre and posttest means and standard deviations for the experimental and control groups.

Table 28

Mean scores on the PTSA Quality of Responses subscale

	Experimental (n=15)		Control (n=15)	
	Pretest	Posttest	Pretest	Posttest
Mean	5.6000	3.0000	4.3333	9.8000
SD	6.1621	4.1231	3.5790	15.2793
Total Cases = 30				

Since the assumption of homogeneity of variance was violated, an ANCOVA was not used to measure the difference between the posttest mean scores of the experimental and control group. Instead, an independent t-test utilizing the gain score as the dependent variable was calculated to determine the difference between the average gain scores for supervisees in the experimental and control group.

Table 29 presents the mean scores, standard deviations and standard error mean for the experimental and control groups.

Table 29

Average gains of supervisees on the PTSA Facilitating Esteem-Building and Encouragement posttest subscale, classified according to the pretest subscale

	N	Mean	Standard Deviation	Std. Error Mean
Experimental	15	-.2.6000	4.3392	1.1204
Control	15	5.4667	14.4956	3.7428
Total Cases = 30				

Table 30 presents the Levene's test for Equality of Variances and statistics for the pooled-variance t-test (used for equal variances assumed) and the separate variance t-test (used for equal variances not assumed). Table 30 shows that there was a statistically significant difference between the average gain scores for the experimental and control groups.

Table 30

Analysis of t-test for equality of mean scores on the PTSAQuality of Verbal Responses subscale

		Equal variances assumed	Equal variances not assumed
Levene's Test for Equality of Variances	F	6.223	
	Sig.	.019	
T-Test for Equality of Means	t	-2.065	-2.065
	df	28.000	16.489
	Sig. (2-tailed)	.048	.055
	Mean Difference	-8.067	-8.0667
	Standard Error Difference	3.907	3.907

Table 30 shows that the assumption of equal variances was violated. Therefore, the Equal variances not assumed t-test results were used. The results show no statistically significant difference at the $<.05$ level ($t = -2.065$ with 16.489 degrees of freedom and significance $< .055$) indicating no statistically significant difference between the experimental and control group's average gain scores on

the Verbal Responses subscale of the PTSA. On the basis of this data, hypothesis 13 was not rejected.

Discussion

The results of this study and verbal and written feedback from play therapy supervisees and supervisors provided information about the effectiveness of a child-centered play therapy self-reflective supervision model. Members of the experimental group increased their ability to utilize five of the ten therapeutic skills assessed by the PTSA at the $< .065$ level. Three of the ten hypotheses measured by the PTSA were statistically significant at the .05 level. These included the therapeutic skills of tracking behavior, facilitating decision-making and self-responsibility and facilitating esteem-building and encouragement. The ability to reflect content was significant at the .064 level and quality of verbal responses was significant at the .055 level. In addition, several measures showed positive trends even though they did not achieve this level of significance. Interpretations of the findings are described in the following sections.

PTAKSS

Play Therapy Skills. As shown in Tables 1 and 2, there was no significant difference between the experimental and

control groups posttest mean scores on the PTAKSS Skills subscale for the experimental and control group. Since the pretest mean scores for the experimental group (3.5588) and the control group (3.7824) were comparable, this suggests that the training play therapy supervisees received prior to the counseling practicum course, created a strong foundation and feeling of confidence in applying play therapy skills. In order to work with a child client in practicum, the supervisee must have completed the 45-hour Introduction to Play Therapy course. This course focuses on helping students develop a child-centered attitude, knowledge about play therapy and confidence in applying play therapy skills. In this course, graduate students observe advanced play therapy graduate students in play therapy sessions at the Counseling and Human Development Center clinic and at the Child and Family Resource Center clinic. They also watch demonstration tapes and role play the therapeutic skills in class. In addition, graduate students participate in two play therapy sessions off-campus. They also conduct between two and four play therapy sessions as part of a mini-practicum on campus and receive immediate feedback from a supervisor and their peers.

Play Therapy Attitude. As shown in Tables 3 and 4, there was no significant difference between the posttest mean scores on the PTAKSS Attitude subscale for the experimental and control group. There was only a very small increase in the experimental and control groups posttest mean scores on the Attitude subscale. The pretest Attitude subscale scores for the experimental group was 3.8404 and 3.8444 for the control group. However, for the reasons mentioned in the previous section on skills, prior extensive training received by the experimental and control group may have already influenced their positive beliefs about children's abilities to learn and guide their own therapeutic process.

Play Therapy Knowledge. As indicated in Tables 5 and 6, there was no significant difference between the posttest mean scores on the PTAKSS Knowledge subscale for the experimental and control group. A very small increase is reported between the pretest and posttest mean scores for the experimental and control group. This suggests that the training and supervision play therapy supervisees received during the counseling practicum course minimally increased their perception of their knowledge about child-centered play therapy. There are two possible explanations for this result. First, play therapy supervisees entered the

supervision experience after completing a 45-semester hour course, Introduction to Play Therapy. This may have accounted for their high pretest mean scores of 4.1016 for the experimental group and 3.9365 for the control group. There is little opportunity to observe significant change when the pretest scores are approximately 4 on a 5 point Likert scale. Second, the information learned during the supervisory experience may have created increased self-awareness about how much they already know and yet how much additional knowledge there is to learn thus, accounting for the small increase in both the experimental and control groups' self-perceptions of ability to apply skills.

PTSA

Tracking Behavior. As shown in Tables 7, 8 and 9, the experimental group showed a significant difference (.051) on the average gain scores of the Tracking Behavior subscale of the PTSA. This can be interpreted to mean that after participating in supervision using the self-reflective child-centered play therapy supervision model, supervisees became more effective at utilizing the therapeutic response of tracking behavior. Supervisees in the experimental group reported greater awareness of quality and quantity of tracking responses after reviewing

videos of their play therapy sessions and completing the Play Therapy Counseling Skills Assessment. During supervision, one supervisee stated: "I had no idea that I was tracking so frequently. My client was probably feeling overwhelmed." Another supervisee stated: "When I reviewed my session and analyzed the quality of my tracking response, I realized how mechanical my voice was. Now I'm aware that I need to be more interactive and conversational." One of the supervisors explained that many supervisees initially view tracking behavior as a simplistic skill used to communicate the play therapist cares and wants to understand what the child is doing. However, the supervisor reported that as supervisees reviewed videos and completed self-assessment forms, they became increasingly aware of how to utilize this therapeutic response with greater authenticity and effectiveness.

Reflecting Content. As indicated in Tables 10 and 11, the F ratio for the main effects was significant at the $<.064$ level indicating a positive trend in the experimental group's increased ability to Reflect Content. A play therapy supervisor stated: "When making a content reflection, several supervisees' struggled with their tone

of voice going up in pitch at the end of a sentence. It makes the reflection sound like they are asking the child a question." The supervisor explained that the Play Therapy Counseling Skills form helped supervisees observe how many times a content reflection sounded like a question. It also helped supervisees become aware of mechanical responses and responses that parroted their client's words or were incongruent with their client's affect.

Reflected Feelings. As shown in Tables 12 and 13, the mean scores of supervisees in the experimental group showed a positive trend towards increasing their ability to reflect feelings. Supervisees stated that reflecting feelings was more difficult than they anticipated. One supervisee explained: "I reflected the child's content when I could have been reflecting feelings. This whole process made me more aware of my client's feelings. The assessment form helped me notice when my voice was incongruent with my client's affect."

Facilitated Decision-Making and Self-Responsibility. As indicated by the data in Tables 14, 15 and 16, the supervisees in the experimental and control groups showed a significant difference (.019) on the average gain scores of the Facilitated Decision-Making and Self-Responsibility

subscale of the PTSA. This can be interpreted to mean that after participating in supervision using the self-reflective child-centered play therapy supervision model, supervisees became more effective at utilizing the therapeutic response of facilitating decision-making. When utilizing this skill, play therapists create opportunities for children to make independent decisions. A supervisee commented: "My first instinct is to answer children's questions as soon as they ask or to assist them as soon as they ask for help. Through journal writing and completing assessment forms, I learned to encourage my client to make her own decisions and to work with the client on putting together the xylophone instead of taking the project over for her."

Facilitating Esteem-Building and Encouragement. As indicated in Tables in 17, 18 and 19, the experimental and control groups showed a significant difference (.006) on the average gain scores of the Facilitated Esteem-Building and Encouragement subscale of the PTSA. This can be interpreted to mean that after participating in supervision using the self-reflective child-centered play therapy supervision model, supervisees became more effective at

utilizing the therapeutic response of facilitating esteem-building.

Directed the Child. As shown in Tables 20 and 21, the experimental and control group showed a positive trend in increasing their ability to encourage the child to lead the therapeutic process.

Setting Limits. As indicated in Tables 22 and 23, the difference between the pretest and posttest mean scores showed a positive trend in the experimental group's ability to effectively set limits. In addition, members of the experimental group articulated a deeper understanding of the rationale for the ACT limit setting model. Supervisees reported that the manual helped them understand the rationale behind utilizing all three parts of the ACT limit setting model. One supervisee explained that she realized how important it was to acknowledge the child's feeling or desire to behave in a specific manner prior to stating the limit. She reported that from reviewing her play therapy session videos and completing the self-assessment forms, she realized that the child responded more frequently to the limit when she utilized the first part of the ACT model. She explained, "From completing the assessment

forms, I also realized how important it was to use the third part of the model and to target an alternative."

Another play therapist explained that the journal entry helped her reflect on the difference between facilitating internal control within the child and imposing her own external control by physically intervening when a child did not respond to the limit. Overall, play therapists remarked that the manual and the assessment forms helped supervisees integrate the rationale for the ACT model and the need to utilize all three parts of the model.

Incongruent Voice. As shown in Tables 24 and 25, the experimental group increased their ability to be congruent during the play therapy session. The difference between the experimental group's pre and posttest mean was 3.0. This score indicated an improvement in the experimental group's ability to be congruent. Whereas, the control group showed a mean difference of -1.0 which indicated a small decrease in their ability to be congruent.

Quality of Non-Verbal Responses. As indicated in Tables 26 and 27, no significant difference or positive trends existed in improving the quality of non-verbal responses.

Quality of Verbal Responses. As shown by the data in Tables 28, 29 and 30, the experimental and control groups showed a significant difference (.055) on the average gain scores of the Quality of Verbal Responses subscale of the PTSA. This can be interpreted to mean that after participating in supervision using the self-reflective child-centered play therapy supervision model, supervisees developed a more conversational quality in their verbal responses. Supervisees reported that watching their play therapy session video and assessing the quality of their verbal responses helped increase their awareness about the mechanical sound of their responses.

Limitations

Although positive trends were evident in the results of this study, the following limitations may have contributed to limited statistical significance.

Sample Representation

Participant selection was limited to play therapy practicum students at the University of North Texas. Prior to participating in the practicum, the supervisees in the control and experimental group received extensive training through enrolling in a 45 hour Introduction to Play Therapy Course. In addition to prior training, the control group

also received a high level of individual and group supervision from doctoral students who had completed a minimum of three forty-five hour courses in play therapy. The doctoral supervisors for the control group had more training in play therapy and more experience in supervision than did the doctoral supervisors of the experimental group. Play therapy supervisees who did not receive as many hours of training may show more significant differences between the experimental and control group when utilizing the Self-Reflective Child-Centered Play Therapy Supervision Model.

Sample Size

The small sample size of this research study (experimental group $n = 15$; control group $n = 14$), resulted in an extremely low power. The observed power on the PTSA ranged between .050 and .461. As a result, there was only a 5%-46% chance of finding significance if it was present. A larger sample size with a minimum power of .80 would enable significant findings to be revealed.

PTSA

The Play Therapy Skills Assessment is a behavioral observation form created for the purpose of this study.

Research on the reliability and validity of this instrument has not been conducted.

Intact Groups

Members of the experimental and control groups were intact groups that were not randomly assigned to receive treatment. The control group was comprised of play therapy supervisees in the Spring 1999 Practicum and the experimental group was comprised of play therapy supervisees in the Fall 1999 Practicum courses. Assigning the experimental and control groups by semester was necessary to avoid the experimental group members sharing the Self-Reflective Supervision Model and the Play Therapy Manual with members of the control group. However, lack of random assignment allowed specific variables to confound the study. For example, the supervisees in the control group had doctoral supervisors who were more advanced in their training than were the supervisors of the experimental group.

Implications

Although only three hypotheses in this study were statistically significant, positive trends were evident when examining the difference between the pretest and posttest mean scores of the experimental and control group.

The positive trends are revealed in the PTSA on the skills of reflecting content, reflecting feelings, setting limits and the quality of verbal responses.

This study is a starting point in understanding the effectiveness of a self-reflective play therapy supervision model. Further research, with a larger sample size in another setting is needed to determine if the supervision model results in statistically significant changes in the play therapist's ability to effectively implement therapeutic responses.

Several doctoral supervisors reported that the manual provided a concise review and rationale for the major therapeutic skills used in child-centered play therapy. They also stated that the self-reflective assessment forms helped supervisees identify their own strengths and areas for growth. One supervisor stated, "I noticed that this group of play therapy supervisees seemed more self-aware and motivated to enhance specific skills."

Supervisees reported that the manual helped provide a concise review of play therapy skills and that the self-assessment forms encouraged a more frequent review of session videos. One supervisee explained, "It helped me focus on specific skills and notice opportunities for

improvement. I entered each new play therapy session with specific skills I wanted to work on." Another supervisee wrote, "I loved having this manual as an overview and quick reference guide when needed. It definitely helped me become more aware of myself and the quality of my therapeutic responses."

This study resulted in positive trends in increasing play therapy supervisees therapeutic skills. Both supervisors and supervisees reported a benefit from utilizing the manual and the self-assessment forms. Therefore, continuation of this project is justified.

Recommendations

Based on the results of this study, the following recommendations are offered:

1. Replicate this study utilizing an increased sample size.
A larger sample size would create a higher statistical power that would increase the chance of finding statistical significance if it exists.
2. Random assignment of experimental and control group would control for extraneous variables such as the supervisors' experience and training.

3. Prior to the implementation of another study, the reliability and validity of the PTSA needs to be determined.
4. Utilize participants who did not participate in a 45-hour introduction to play therapy course.

Concluding Remarks

This was the second experimental study published about the effectiveness of a play therapy supervision model. Results show a positive trend in the play therapy supervisees' ability to implement therapeutic responses. The positive trends warrant continued implementation of this study. The information in the recommendation section will increase the possibility of a more thorough statistical analysis of data.

APPENDIX A
INFORMED CONSENT FORMS

PLAY THERAPY SUPERVISION STUDY

All play therapy students who are enrolled in the master's practicum are invited to participate in a study to determine the effectiveness of the "Play Therapy: Self-Assessment of Therapeutic Responses" in the play therapy supervision process. This study will be conducted during your first ten play therapy sessions.

If you choose to participate, you will be asked to agree to the following.

I grant permission for my first and one of my last play therapy sessions of the practicum to be videotaped and evaluated. I also agree to complete and return:

- the Play Therapy Attitude, Knowledge, and Skills Survey at the beginning and at the end of the semester
- weekly self-assessments based upon my review of my play therapy session video tape
- a self-evaluation of my play therapy skills at the beginning and at the end of the semester

I am aware that Maria Giordano, research assistant, will keep all information confidential and that I will be identified only by the numerical code assigned below. I am also aware that my assessments and evaluations will not be seen by or discussed with my professors. In addition, all information gathered in this study will not affect my grade in practicum.

I have been informed that there is no personal risk directly involved in participating in this research study. I realize that I am free to withdraw my consent and discontinue participation in this study at any time. If I have any questions or concerns that arise as a result of my participation in this study, I should contact, research assistant Maria Giordano at (972)434-1684, or Dr. Garry Landreth at (940)565-2910, or Dr. Sue Bratton at (940)565-2066.

Name of Participant

Code Number

- If you agree to participate, please sign the attached consent form and return it to the doctoral supervisor in your Practicum.

This project has been reviewed and approved by the UNT Committee for the Protection of Human Subjects (940)565-3940.

INFORMED CONSENT

PLAY THERAPY SUPERVISION STUDY

You are making a decision whether or not to participate in this study. You should not sign until you understand all the information presented on this form and until all your questions about the research have been answered to your satisfaction.

You understand that participation is voluntary and you may choose to withdraw at any time during the study. Your signature indicates that you meet all the requirements for participation as explained by Maria Giordano and have decided to participate.

Name of Participant

Signature of Participant

Date

Signature of Witness

Date

Signature of Investigator

Date

This project has been reviewed and approved by the UNT Committee for the Protection of Human Subjects (940)565-3940.

Counselor Education
University of North Texas
COUNSELING AND HUMAN DEVELOPMENT CENTER

PERMISSION TO USE COUNSELING VIDEOTAPE FOR
EDUCATIONAL & RESEARCH PURPOSES

To: CHDC Clients

University of North Texas
Denton, TX 76203-6857

I understand that videotapes of my counseling sessions have value for educational and research purposes for counselors in training in Counselor Education classes. I further understand that any Counselor Education student who sees a videotape will be reminded of rules of confidentiality that prohibit the discussion of the videotape except for professional training and research purposes. I hereby give my permission for videotapes to be so use:

Client Name _____

Client Address _____

Client Signature _____ Date _____

Counselor's Signature _____ Date _____

APPENDIX B

PLAY THERAPY ATTITUDE-KNOWLEDGE-SKILLS SURVEY

Play Therapy Attitude-Knowledge-Skills Survey

This survey is designed to provide the play therapy trainer information regarding the attitude, knowledge and skills of a group of trainees. It is not a test. No grade will be given as a result of completing this survey. Please read each statement/questions carefully. From the available choices, circle one that best fits your reaction to each statement/question. Thank you for your cooperation.

Male _____ Female _____ Age _____

Courses taken in play therapy field: (circle) 0 1 2 3 4+

Clinical experience in play therapy: (circle)	None	Under 1 yr	1 yr
	2 yrs	3 yrs	4+ yrs

Play therapy workshop attended: (circle)	0	1-3 days	4-6 days
	7-10 days	11+ days	

Work experience with children: (circle) None School teacher Child care
Other (Specify)

Please indicate your response for each statement in the following manner:

1 – Never 2 – Seldom 3 – Sometimes 4 – Often 5 – Always

	NEVER	1	2	3	4	ALWAYS
1. I enjoy being child-like sometimes.		1	2	3	4	5
2. I am accepting of the child part of myself.		1	2	3	4	5
3. I enter new relationships with children with confidence and relaxation.		1	2	3	4	5
4. I am a warm and friendly person to children.		1	2	3	4	5
5. I usually provide too many answers to children.		1	2	3	4	5
6. I have a high tolerance for ambiguity.		1	2	3	4	5
7. I am vulnerable and make mistakes at times.		1	2	3	4	5
8. I know myself and accept myself as who I am.		1	2	3	4	5
9. I have a sense that children trust me.		1	2	3	4	5
10. I appreciate my childhood.		1	2	3	4	5

Please indicate your agreement or disagreement with each statement in the following manner:

1 Strongly Disagree 2 Disagree 3 Undecided 4 Agree 5 Strongly Agree

- | | |
|---|-----------|
| 11. Children's behavior is usually unpredictable. | 1 2 3 4 5 |
| 12. The underlying motivation of children's behavior can be understood. | 1 2 3 4 5 |
| 13. Children are basically miniature adults. | 1 2 3 4 5 |
| 14. Children are irresponsible. | 1 2 3 4 5 |
| 15. Children possess a tremendous capacity to overcome obstacles and circumstances in their lives. | 1 2 3 4 5 |
| 16. Children's behavior is usually unexplainable. | 1 2 3 4 5 |
| 17. Since children are in the process of developing, they do not usually experience the depth of emotional pain adults are capable of experiencing. | 1 2 3 4 5 |
| 18. Children are capable of positive self-direction if given an opportunity opportunity to do so. | 1 2 3 4 5 |
| 19. How things seem to children is more important than what has actually happened. | 1 2 3 4 5 |
| 20. Children's behavior needs to be molded and directed for optimal growth and adjustment. | 1 2 3 4 5 |
| 21. Children's behavior is usually understandable. | 1 2 3 4 5 |
| 22. Children can be helped to grow and mature faster. | 1 2 3 4 5 |
| 23. Children usually need considerable structure and direction since they are still learning and developing. | 1 2 3 4 5 |
| 24. Children are capable of figuring things out. | 1 2 3 4 5 |
| 25. Children are resourceful. | 1 2 3 4 5 |
| 26. Children are unkind. | 1 2 3 4 5 |
| 27. Children tend to make the right decision. | 1 2 3 4 5 |
| 28. Children need a capable adult to point them in the right direction. | 1 2 3 4 5 |
| 29. Children think before the act. | 1 2 3 4 5 |
| 30. Children are capable of insight and their own behaviors. | 1 2 3 4 5 |

31. Children are unfeeling.	1	2	3	4	5
32. Children can be trusted.	1	2	3	4	5
33. Children will out grow most of their problems.	1	2	3	4	5
34. Most children are able to express their feelings, frustrations, and personal problems through verbal expression.	1	2	3	4	5
35. Adjusted and maladjusted children express similar types of negative attitudes.	1	2	3	4	5
36. Most children need direction from a counselor to work out solutions to their own problems in a counseling relationship.	1	2	3	4	5
37. Typically, an adult must intervene physically or directly to stop most children's aggressive and/or destructive behavior.	1	2	3	4	5
38. Children communicate in much the same way as adults.	1	2	3	4	5
39. Adult counselors and play therapists use similar techniques.	1	2	3	4	5
40. Children's natural medium of communication is play and activity.	1	2	3	4	5
41. How the therapist feels about the child is more important than what the therapist knows about the child.	1	2	3	4	5
42. Children do not have emotional disturbance problems. They just lack education and training.	1	2	3	4	5

Please indicate your response for each statement in the following manner.

1 - None 2 - Very Limited 3 - Limited 4 - Good 5 - Very Good

	LOW					HIGH				
43. In general, how would you rate your knowledge of play therapy as an approach for counseling with children?	1	2	3	4	5					
44. How would you rate your understanding of the reasons for selecting and excluding toys and materials in play therapy?	1	2	3	4	5					
45. How would you rate your awareness of your own feelings when you are relating to children?	1	2	3	4	5					
46. In general, how would you rate your knowledge of how children communicate?	1	2	3	4	5					
47. In general, how would you rate your knowledge of identifying areas where limits should be set.	1	2	3	4	5					

At the present time, how do you rate your understanding of the following terms.

48. "Play theme"	1 2 3 4 5
49. "Tracking"	1 2 3 4 5
50. "Returning responsibility"	1 2 3 4 5
51. "Therapeutic limit setting"	1 2 3 4 5
52. "Choice giving"	1 2 3 4 5
53. "Play materials"	1 2 3 4 5
54. "Play therapy"	1 2 3 4 5

55. How would you rate your ability to conduct a play therapy session with a child. 1 2 3 4 5

56. How would you rate your ability to effectively assess the mental health needs of a child? 1 2 3 4 5

57. How well would you rate your ability to distinguish differences in counseling adults and children? 1 2 3 4 5

58. How would you rate your ability to identify the strengths and weaknesses of verbal therapy in terms of their use with different age children? 1 2 3 4 5

59. How would you rate your ability to relate to children. 1 2 3 4 5

60. How would you rate your ability to achieve the frame of reference of a child? 1 2 3 4 5

61. In general, how would you rate yourself in terms of being able to effectively deal with a silent child in play therapy? 1 2 3 4 5

62. How would you rate yourself in terms of being able to effectively deal with an aggressive child in play therapy? 1 2 3 4 5

63. How would you rate yourself in terms of being able to effectively deal with a reluctant or anxious child in play therapy. 1 2 3 4 5

64. How well would you rate your ability to discuss the issue of confidentiality with parents? 1 2 3 4 5

65. How would you rate your ability to help parents understand their children? 1 2 3 4 5

66. In general, how would you rate your ability to accurately articulate a child's problem? 1 2 3 4 5

67. How would you rate your ability to critique a play therapy session? 1 2 3 4 5

- | | |
|---|-----------|
| 68. How will do you think you could identify play themes in a play therapy situation? | 1 2 3 4 5 |
| 69. In general, how would you rate your skill level in terms of being able provide appropriate counseling services to children. | 1 2 3 4 5 |
| 70. How would you rate your ability to effectively consult with another mental health professional concerning the mental health needs of a child? | 1 2 3 4 5 |

Rate your ability to:

- | | |
|--|-----------|
| 71. communicate to a child your understanding of the child's feelings and play activity in play therapy. | 1 2 3 4 5 |
| 72. select appropriate toys for play therapy. | 1 2 3 4 5 |
| 73. identify children's emotions in play therapy. | 1 2 3 4 5 |
| 74. structure the play therapy relationship. | 1 2 3 4 5 |
| 75. understand symbolic play in play therapy. | 1 2 3 4 5 |
| 76. understand the meaning of children's questions. | 1 2 3 4 5 |
| 77. communicate the steps in therapeutic limit setting. | 1 2 3 4 5 |
| 78. set limits on children's behavior in play therapy. | 1 2 3 4 5 |
| 79. establish a facilitative relationship with a child in play therapy. | 1 2 3 4 5 |
| 80. build children's self-esteem without causing dependency in play therapy. | 1 2 3 4 5 |
| 81. track a child's behaviors in play therapy. | 1 2 3 4 5 |
| 82. reflect children's feelings in play therapy. | 1 2 3 4 5 |
| 83. reflect the content of children's play in play therapy. | 1 2 3 4 5 |
| 84. facilitate children's spontaneity and creativity in play therapy. | 1 2 3 4 5 |
| 85. facilitate decision-making and responsibility by children in play therapy. | 1 2 3 4 5 |
| 86. verbally match the affective and activity pace of a child in play therapy. | 1 2 3 4 5 |
| 87. Be succinct and specific in communicating with children in play in play therapy. | 1 2 3 4 5 |
| 88. For self-supervision of counseling relationships with children. | 1 2 3 4 5 |

APPENDIX C

PLAY THERAPY SKILLS ASSESSMENT-RATER

PLAY THERAPY SKILLS ASSESSMENT - RATER

Play Therapist's Name/Participant's Code

Please Print – Rater's Name

- Make a tally mark each time a response meets the criteria in each row.
- Make only one tally mark per response in each bold-faced heading.

TRACKED BEHAVIOR		
Overwhelming or too few (*1 min.)		
Tone of voice goes up		
<i>*Mechanical – rehearsed</i>		
<i>*Voice incongruent</i>		
REFLECTED CONTENT		
Missed opportunity		
Exact same words		
Tone of voice goes up		
<i>*Mechanical – rehearsed</i>		
<i>*Voice incongruent</i>		
REFLECTED FEELINGS		
Missed opportunity		
Tone of voice goes up		
<i>*Mechanical - rehearsed</i>		
<i>*Voice incongruent</i>		
ESTEEM-BUILDING		
Missed opportunity		
Praised or evaluated		
<i>*Mechanical – rehearsed</i>		
RETURNED RESPONSIBILITY		
Missed opportunity		
Helped child inappropriately		
Answered questions		
<i>*Mechanical - rehearsed</i>		
SET LIMITS		
Missed Opportunity		
Set limit / Did not use ACT model		
Used 1 part of ACT model		
Used 2 parts of ACT / not feeling		
Used 2 parts of ACT / not limit		
Used 2 parts of ACT/ not alternative		
DIRECTED CHILD		
Comments directed		
Asked questions		
NONVERBAL RESPONSES		
Preoccupied – uncomfortable (1 min.)		
Disinterested (1 min.)		

- Circle the tally mark if the response was appropriate.

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